DOCUMENT RESUME

ED 036 742 AC 006 537

AUTHOR Buckland, Jean Kirstine
TITLE An Institute as an Educational Experience in the Continuing Education of a Selected Population of Nurses.
INSTITUTION British Columbia Univ., Vancouver.
PUB DATE 69
NOTE 155p.; M.A. Thesis

EDRS PRICE EDRS Price MF-$0.75 HC-$7.85
DESCRIPTORS Analysis of Variance, *Behavior Change, Changing Attitudes, Educational Background, Employment Patterns, *Evaluation, *Evaluation Techniques, Experience, *Institutes (Training Programs), Knowledge Level, Masters Theses, *Nurses, Professional Continuing Education, Self Evaluation, Socioeconomic Background

ABSTRACT

This study evaluated a two day institute as a means of continuing education for nurses, analyzed a method of evaluation, and examined the relationship of education and experience to subsequent learning. Background data were gathered by a structured questionnaire; unstructured interviews elicited what participants thought they had learned. Of the total sample, 91% perceived changes in their own behavior; 76% saw changes in knowledge, 62% in attitude, and 76% in practice. Over half perceived change in all three areas. The greatest change was perceived by those who were younger, married, had less education (academic and post basic nursing), less nursing experience, and were employed in the larger agencies. Little or no change was noted by those who had more education and experience and were employed with smaller agencies. Learning correlated slightly with age, basic academic education, post basic nursing education, nursing experience, and size of employing agency. It was concluded that the institute was effective for the three kinds of learning provided that the credibility of respondents was acceptable. The evaluation method (with the above proviso) was adequate for indicating change, but not for showing relationships to certain socioeconomic data. (author/ly)

AN INSTITUTE AS AN EDUCATIONAL EXPERIENCE IN THE CONTINUING EDUCATION OF A SELECTED POPULATION OF ADULTS

Jean K. Buckland

AN INSTITUTE AS AN EDUCATIONAL EXPERIENCE IN THE CONTINUING EDUCATION OF A SELECTED POPULATION OF NURSES

by

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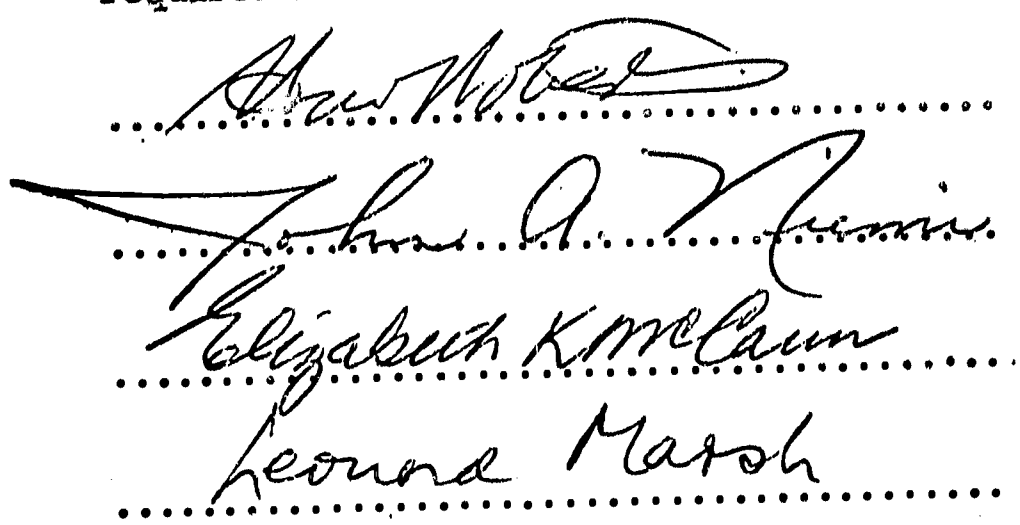
B.A.Sc., University of British Columbia, 1945

A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF ARTS

in the Department of Adult Education

We accept this thesis as conforming to the required standard



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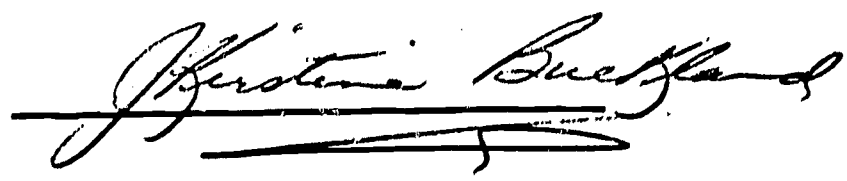

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ABSTRACT

This study was an effort to evaluate the effectiveness of a two day institute on "Evaluation of Personnel" as an educational experience in the continuing education of nurses, to submit to critical analysis a method of evaluation, and to examine the relationship of educational and experiential backgrounds of the participants to the learning which took place subsequent to an observational analysis of the institute. An unstructured interview technique was used three months after its completion to elicit subjectively what respondents thought they had learned at the institute. The information was later arranged in a structured format for compilation, tabulation and analysis, both by punch card and computer. The socioeconomic background data was gathered through the use of a structured questionnaire at the time of the inteview. A behavioral concept of learning was used throughout.

The results revealed that 91% of the sample indicated that learning had occurred, as they perceived a change in their behavior because they had attended the institute. Further, 76% perceived a change in knowledge, 62% in attitude, and 76% in practice, while over half perceived a change in all three areas. The greatest change was perceived by those who were younger, married, had less education (academic and post basic nursing), less experience in nursing, and

who were employed in the larger agencies. The perception of little or no change was indicated by those with more education (academic and post basic nursing), more experience in nursing, and who were employed in the sm ller agencies.

The comparisons of change to background factors revealed that, although none of the comparisons were consistently significant, there was a positive relationship of learning with age, basic academic education, post basic nursing education, years of nursing experience, and size of employing agency. Marital status, husband's occupation, parental status, income, social participation, years of head nurse experience, size and type of nursing unit and size of staff showed some interesting comparisons by observation, but the sample proved too small for accurate inferences to be drawn.

The conclusions of the study were that the institute was effective as an educational experience for continuing education in the three aspects of behavioral learning examined, provided the credibility of the respondents was acceptable. The instrument used was adequate for the purpose of indicating change of behavior with the above proviso, but not adequate for revealing whether change was relevant to certain socioeconomic data. No claim can therefore be made concerning the relationship between this data and learning in a situation such as this institute.

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ACKNOWLEDGMENTS

"No man is an island...." This familiar quotation of John Donne is always applicable when one attempts a foray into unfamiliar territory.

The author is indebted to the many head nurses who co-operated so willingly and with so much interest in this study; to their directors of nursing and supervisors who gave of their time to arrange interviews during on-duty hours; to fellow graduate students who were unstinting in their comments, support and coercion, as well as in their overwhelming advice and donations of literature; and to many others at the University and in the hospitals who donated effort and time to speed this paper to completion.

Special thanks are due to my advisory committee, Dr. John Niemi, Dr. Leonard Marsh and Miss Elizabeth McCann, for their time and patience.

The author is particularly grateful to Dr. Hew Roberts for his unfailing positive approach to life's problems, and to Mrs. Doris Christian for her perseverence in the face of adversity.

Last but not least, this thesis was possible due to the forbearance of my children during its development and fruition.

CHAPTER I

THE PROBLEM, THE RELEVANT RESEARCH, THE STUDY

Social and Occupational Change

As the social institutions of our society have become increasingly bureaucratic, the need for personnel with administrative skills in the management of people and production has increased. The production explosion of the Second World War demonstrated the results of inadequate and inexperienced managerial personnel.[1] It also demonstrated the effects of training these people how to supervise and teach their subordinates. Training usually resulted in increased production and decreased turnover of personnel in both industry and business.

Nursing, like many professions, has undergone major changes in the past twenty-five years. Some of these changes have had internal causes, but many have been influenced by technical changes in the medical and paramedical fields. Although constant changes may make an occupation more interesting, they may also constitute a threat to those with feelings of inadequacy in a shifting situation. Many problems and general unrest among nursing personnel have been created, causing decreased quality of nursing service, high turnover of staff,

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[1]References will be collected at the end of each chapter.

and increased cost in staff replacement.

Lack of Leadership

The graduate nurse has been educated to give direct patient care rather than to assume administrative duties and to direct the work of others, such as are inherent in the leadership role.[2] Many nurses have found themselves in leadership and supervisory positions with the resulting conflicts between what they learned to do and what they were actually doing in the everyday work situation.[3] Approximately 23% of nurses in Canadian general hospitals were in positions of assistant head nurse or higher in 1967.[4] The number of people required for administrative functions has always exceeded the number available with the necessary leadership and supervisory preparation.[5]

Various nursing studies have concluded that twenty-five to thirty-three percent of nursing positions need as one requirement a baccalaureate or higher degree.[6] Countdown 1968 stated that of 120,000 registered nurses in Canada in 1967, 5% had a baccalaureate degree in nursing, 0.4% had a higher degree, 9% had some credits toward a baccalaureate degree, and 8% had a university diploma or certificate in nursing.[7]

In 1966, one study reported that, of one hundred head nurses, four had a degree, twelve had a one year university diploma course in nursing, eleven had a hospital clinical course, and four had completed a correspondence course in nursing unit administration.[8] (Appendix A).

In 1967, Mussallem stated that there was "a colossal waste of nursing skills," which she attributed to poor supervision and high

staff turnover.[9] Lack of preparation caused supervisory personnel uneasiness and feelings of inadequacy, which often undermined the security and confidence of their subordinates. Lack of preparation also made their administrative functioning inadequate in many cases. One Canadian study on staff turnover indicated that work load was the largest single significant factor involved.[10]

The cost of replacing those who leave their positions involves money, effort, and time for the employing agency and for the employees who remain. One American study estimated the personnel processing cost of replacing one general staff nurse in a general hospital to be five hundred dollars.[11] Since there was an estimated 61% turnover rate for general staff nurses in Canada in 1967, the implications of the American study are obvious.[12] Turnover rates were 16% for head nurses, 16% for supervisors and 17% for hospital nursing directors in 1966.[13] The highest turnover of all nursing positions was greatest in hospitals of over 300 beds.[14]

The Canadian Nurses Association outlined the factors involved in job satisfaction which, it believed, would influence the high rate of turnover of all nurses.[15] These factors included orientation procedures, administrative policies, personnel policies, inservice education, staff organization, supervision and evaluation, the opportunity for advancement, participation in professional organizations, and further education. A consideration of the quality of these factors might actually decrease the turnover rate.

Continuing Education for Nurses

Both the Canadian and American Nursing Associations have reported that nurses are asking for continuing education programs to add to their basic knowledge and to meet their developing needs.[16,17] Many of these needs have arisen through changing technical knowledge, but many have arisen through the promotion of the nurse into supervisory positions for which she was not fully prepared. Employing agencies have been interested in updating their staff members because improved knowledge has usually improved the quality of patient care. Most hospitals have provided inservice education programs for various levels of workers to keep them up to date with changing practices. Also, staff members have usually been encouraged to attend whatever educational courses are available.

A large number of short term training courses, institutes, and workshops have been conducted for nurses during the past ten years in both Canada and the United States. No matter how good the basic preparation of the nurse may have been, such courses were considered necessary for her to keep up with current knowledge.

Many short courses have been given in administrative and leadership subjects to enable those without sufficient preparation for their positions to function more adequately. The courses were considered stopgaps which would continue only until enough properly prepared people became available. Baccalaureate programs are increasing across Canada, and several universities now offer Masters' programs. As graduates from these programs become more numerous, the need for

short courses in administration and leadership may be expected to decrease except as refresher courses.

In the United States, over 10,000 nurses, or roughly 15% of those eligible, attended 300 courses in management training between 1960 and 1963.[18] A nursing unit administration correspondence course has been completed by over 1,500 Canadian head nurses and supervisors since its inception in 1960.[19] A summary and evaluation of this course is given in Appendix A. Recently the number of applicants has exceeded the enrollment capacity of the course. Hereinafter this course is referred to as the N.U.A. course.

Evaluation of Continuing Education

Many nursing and educational groups across the country have instigated programs of management training for key personnel in nursing.[20,21] This has been done in an effort to increase the utilization of available staff through their improved effectiveness as a result of attending such programs. From a practical standpoint, the results have been disappointing to researchers as improved performance has not always occurred subsequently.[22] Nursing leaders have felt that lip service rather than changed performance has resulted.[23] Behavioral researchers, however, regard any change following a program as progress.[24]

Cheek and Gruenfeld write, "While management development programs apparently fail in their manifest functions, they serve a number of equally important latent functions."[25] One of these latent functions was the changed view of themselves and their jobs which

participants often had. With this changed view, the participant was likely to function differently on her return to her job, with results which were likely to be beneficial to both herself and her employing agency. A speaker at a conference on the professional nurse traineeship program stated, "There is no known method of statistically measuring the quality contributed by an educated spirit as well as an educated mind. Nor is it easy to assay the illimitable influence of leadership."[26]

Studies germaine to the evaluation of continuing educational experiences for nurses were reviewed, and are summarised below.

The Utah Study. In 1960, a regional continuing education project was started at the University of Utah College of Nursing to improve the skills of nurses in administrative, supervisory and teaching positions.[27] Six short conferences were held over a two year period with thirty of the original thirty-four participants completing the series. The program "was designed to make changes in the direction of greater understanding and more democratic attitudes on the part of participants." Evaluation of the program had as its objective determination of the extent to which learning and/or attitude change took place following the educational experiences.

The evaluation instruments used were: a) a special trait check list, b) the Helen B. Lenehan Inventory of Nursing Routines, c) a Superordinate Interview Scale, d) a WICHE Supervisor Rating Scale, and e) a Subordinate Rating Scale. The first two scales were discarded

because they were judged as not sensitive enough. The last three scales covered, to different degrees, but generally, the areas of efficiency, competence, initiative, stress, and interpersonal relationships. Superordinate and/or subordinate ratings were obtained on all participants and on 23 control subjects by the same person both before and after the series of conferences, approximately two years apart. Of the conference participants, 30% were evaluated by the superordinates and subordinates as needing little or no training, and the other 70% were evaluated as needing training to some extent in all areas. The control group did not attend any of the conferences.

The conclusions of the study were that the conference participants improved while the control non-participants did not. The results were strongly suggestive that the conferences were responsible for the improvements. Of the instruments used, two were judged not sensitive enough, one was questioned as being somewhat unreliable, and no specific comments were made concerning the others.

The WICHE Study. Under the aegis of the Western Interstate Commission on Higher Education, eight university schools of nursing in twelve western states carried out seven leadership training programs.[28] Each trainee attended six one week conferences over a two year period. The major objective was to aid the participants in becoming more effective leaders, on the assumption that effective nurse leaders create a climate in which high quality nursing care can be provided by their staffs. Using new approaches to learning, it was hoped that

greater group awareness and acceptance of the need for change would develop. The aims of a concurrent research project were to develop instruments for evaluating selected attitudinal and behavioral changes, to test the reliability of the instruments developed, and to determine the degree of change resulting from participation in the continuing education program.

An experimental group of 410 nurse leader participants and a control group of 450 nurse leader non-participants were compared on several research devices and instruments both before and after the two year program. Overt behavior was measured with a situational exercise by three people, and by rating scales for on-the-job leadership and interpersonal skill by one supervisor and three subordinates. Both groups of subjects also completed: a) the Nahm Nurse Opinion Inventory, b) the Todd Personnel Relations Test Part I and Part II. As well as the above, the experimental group, half way through the program, was given a) the Biographical Inventory, b) the Registered Nurse's Self Description Scale, and c) the Registered Nurse's Satisfactory Achievement Scale.

The research results indicated a change in the desired direction of expressed attitudes and beliefs regarding leadership and interpersonal relationships. However, changes in behavior to correspond with the attitudinal changes were not clearly demonstrated.

The authors agreed that the participants had identified with more democratic and understanding attitudes, but that the pressures of the day-to-day work situation were against change. As the seminars or

conferences were only interruptions in the usual pattern of work, it was difficult to break through the barriers of apathy to obtain personal involvement and commitment. The roles and relationships in nursing have been very ambiguous, and become further complicated by the individual nurse's perception of her responsibility for nursing care. They concluded, however, that any movement in a positive direction was progress. The report stated that the instruments developed were inadequate.

The Texas Study. In 1958 an acute shortage of nurses in the State of Texas precipitated a two year survey of nursing needs and resources.[29] A proposal for improving conditions through "strengthening the skills of those who are now responsible for directing the nursing care of patients" resulted.[30] A Management Skills Training Workshop for 'nurse managers' was set up, and in 1960 three five day workshops followed by a three day workshop were instigated over a seventeen month period for each nurse participating. During the four years of the project, 1,700 nurses, or 28% of those eligible, took part.[31]

The assumptions underlying the program were that training based on changing attitudes would lead to changes of behavior, as changing attitudes and values are part of occupational socialization. Occupational socialization was defined as "a process by which individuals selectively acquire the skill, knowledge, attitudes, values, and motives current in the groups of which they are, or will become, members."[32] The report explained that those changing their occupational

role, from bedside nursing to the supervision of others doing the bedside nursing, needed to change their value systems to those of the work group which they had joined. The research project method was to gather information regarding short and long term effects of the program on the participants and on their employing agencies.

During the training program, six multi-item instruments were used at various stages. Two were devised specifically for measuring information in this study, and four were modified from attitude scales developed for other studies. The first information test was constructed by the project members but discarded later, as seven of the original fifteen items were judged not discriminatory enough. The second information test was developed from an analysis of training publications and consisted of 26 items, of which 17 were found to be sufficiently discriminatory. The four attitude scales were a) the democracy scale, b) the functional orientation scale, and c) the consideration and initiating structure scales. The instruments were considered relatively reliable as the coefficients reported were comparable to those reported for similar short tests.

The study revealed a change in knowledge for all participants,[33] and a change of attitude toward more democratic and functional orientations for most participants. These attitudes tended to persist and in the predicted direction.[34]

Performance evaluation, or a change in practice, was determined through three different types of special sub-studies. These were, essentially, a) a Proficiency Rating System used in the Veterans

Administration hospitals (80 participants), b) the Nurse Management-performance Instrument used in 8 hospitals (41 participants), and c) an interview and questionaire used in six hospitals (11 participants). For the last performance evaluation sub-study, control "cases" were matched with the experimental "cases." These "cases" each included the participant, one supervisor and two subordinates.

The number of persons given above were those followed throughout the study. Because of technical difficulties, the original interviewees were reduced to these numbers and the samples were not considered as random selections of conference participants.

The attainment of attitude change occurred in the first performance evaluation sub-study but there was little evidence of performance change. The second sub-study reported performance improvement at the lowest level of conventional confidence. This group showed significant but low correlations between changed attitudes and changed performance. The third sub-study did not prove that improvement occurred, but did reveal that the social structures of the work group can impede or permit changes and that there was little evidence that experimental "cases" would change their performance more than the control "cases." The results tended to both support and negate the expected performance change.

The report then stated that evaluation of change and actual change could be contradictory. In support of this the authors examined self reports of performance change and reports of changes in the employing agencies of the participants. Self reports of performance

change varied from none to many, with areas of change different from those anticipated. Performance improvement was evidently not general, but in specific areas which had been given low priorities on the original assessment. Agency changes were reported by over half the directors employing participants as either new practices being instituted or existing practices being improved. In one way or another, a change in performance occurred for most participants, although the authors stated that those who were pleased with the conferences may have had inflated ideas of the amount of change which actually occurred.[35,36]

In the conclusions of the study the authors discussed the controversies which exist over which criteria may be accepted as indicative of success, and over the level of attainment of these criteria before the outcome is judged as successful.[37] From a social research[38] viewpoint, the program was successful, determined from both attendance of initial participants, and their degree of satisfaction with the program. The latter varied depending upon the education and experience of the participants. The final statement of the study is

> This report has shown clearly that it <u>is</u> difficult to demonstrate that a management-training program has achieved its objectives, that the trail of cause and effect <u>is</u> hard to follow, that criteria <u>are</u> hard to select and measure, and that judgment <u>is</u> an essential part of the process.[39]

Relevance of the Present Study

The previous studies were concerned with courses or conferences while the present study is concerned with an institute.

An institute, in continuing education terminology on this continent, is a one to three day program of lectures or presentations, alternated with group discussions.[40] In the inexact terminology of continuing education, the institute can also be described as a study-conference, refresher-conference, or short school. The participants usually have a common occupational or professional background and gather to add new information to their basic knowledge of a particular aspect of their field. Institutes are described as most advantageous for the acquisition of knowledge rather than for practicing or applying it.[41,42,43,44]

Those attending the institutes under study held assistant head nurse positions or higher in their employing agencies.[45] Geitgey described a head nurse as the immediate supervisor of an individual ward or clinical area.[46] Her supervisory and educational efforts are directed to the greater efficiency and better performance of her staff members for the improvement of the nursing care of the patients in her area.

The supervision and evaluation of personnel was the subject of the institutes. This aspect of administration has often been a source of anxiety, conflict, and confusion to many in supervisory positions, but especially to those without preparation because they have not understood the rationale and implications of the processes involved.[47,48,49]

This study was an approach to the evaluation of an institute as an educational experience in the continuing education of a sample of the participants. The reader will observe that none of the studies

reviewed were concerned with an educational experience as intensive as this two day institute.

Purpose and Scope of the Study

The purposes of the present study were: 1) to evaluate an institute as an effective tool in continuing education for nurses, and 2) to subject a method of evaluation to critical analysis. Evaluation of the institute was attempted through 1) a subjective evaluation by the selected sample of their perception of change in their own behavior following participation in the institute; 2) an analysis of perceived change in knowledge, attitude, practice, or a combination of these, and 3) an examination of whether differences in perceived changes were related to differences in educational and experiential background (general and professional).

Provision for increasing knowledge and for modifying attitudes can be included in a well designed two day institute. Information about improving practice can be provided, but provisions for application cannot. The institute under study was therefore subjected to an observational analysis in terms of knowledge, attitude, and relevance to practice. Summary mention of the governing factors in this analysis is given in Chapter III. As the analysis is based on the behavioral concept of learning, a review of the literature on learning and the factors influencing it can be found in Appendix E. As the motivation for continued learning, and employment itself, may be conditioned by socioeconomic factors such as the need to earn

money, a secondary exploration of the correlation between expressed opinions and selected socioeconomic aspects of the participants was undertaken.

The study was exploratory in that the methodology and results might contribute to further studies in evaluation from which conceivably appropriate instruments and techniques for objective measurement may be developed in the future.

The sample used for the study was randomly selected from a population consisting of those registered nurses attending the institute who lived within a certain geographic area. Each nurse was interviewed individually by the author, usually at the nurse's place of work. The interviews were held over a six week period starting approximately three months after completion of the institutes.

The interview used in this study consisted of a) formal questions concerned with socioeconomic and demographic data about the individual, and b) a discussion to elicit those changes of behavior perceived by the person as occurring because she had attended one of the institutes.

Limitations of the Study

This study was concerned only with the interviewee's perception of any change in her behavior because she attended the institute. As with any subjective study, this one was limited by the subjective attributes of the interviewees regarding their perception of their own behavior, and the impressions of the interviewer regarding these statements. Changes may or may not have occurred, although the interviewee may have felt that she should show a positive appreciation of the institute as she had been chosen in the

interview sample. Interviewer-interviewee interaction could also have affected the outcome of the study, particularly when the recording and measurement of changed behavior was dependent upon unstructured interviews.

There was no way of predetermining the composition of the population or of pretesting the individual's unique procedures of evaluating staff performance before the institute. In any event, no standard measures of staff performance evaluation techniques have yet been established.[50,51,52,53]

Apart from practical difficulties, there is a theoretical basis for the avoidance of pretests or baseline tests in studies of subjective evaluations as distinct from objective measurement of newly acquired knowledge. When the respondents are aware of what is expected, the halo effect is more in evidence than would otherwise be the case.[54]

The sample could have been affected positively or negatively by those respondents who were just completing the N.U.A. course (Appendix A). This was not known before the interviews. The population from which the sample was selected, although geographically limited, proved to be characteristic of the population and the profession in major socioeconomic factors.

The sample, including the socioeconomic and demographic information gathered during the interviews, is the subject of the next chapter.

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CHAPTER II

A DESCRIPTION OF THE SAMPLE

The Population and the Sample

A two day institute on "The Evaluation of Personnel" was held twice in Vancouver, B. C., in March 1968. It was conducted by Miss K. Ruane of Winnipeg, under the sponsorship of the Registered Nurses Association of British Columbia, and the Department of Continuing Medical Education, University of British Columbia.

There were 242 registered nurses participating in these institutes, all of whom were employed as assistant head nurses or higher. The population for the study consisted of those living within a one-hundred mile driving radius of Vancouver, B.C., and was chosen for easy accessibility for interviews. The resulting number of registered nurses was 189.

From this population of 189, a 35% sample was chosen from random number tables,[1] using alphabetically listed names of participants.[2] This sample list included a 25% study sample and a 10% alternate list. As the interviews were held during the summer months when vacations occur, it was anticipated that some of the sample might be unavailable. The final sample included only two from the alternate list to replace two who had left British Columbia since the institute.

Background data were gathered in order that differences among

those comprising the study sample might be identified. A structured interview schedule was designed to seek the following facts: marital status, including the husband's occupation [3] and parental status of those married; age; income; social participation rating;[4] basic academic education; non-nursing education; location of school of nursing associated with basic nursing education; year of graduation; type of hospital associated with school of nursing; amount and type of post basic nursing education; years of nursing experience; years of head nurse experience; size of employing agency; type of nursing unit; size of nursing unit; size of staff; and perception of the institute.[5]

The resulting interview schedule is in Appendix B. From the answers to this schedule obtained during the pilot study (discussed in Chapter III), it was decided that the questions were suitable for use as an instrument without change.

Characteristics of the Sample

The data in this section were derived from the interview schedule, recorded on punch cards and tabulated. This was later verified by univariate tabulations on a computer. The answers to each question regarding background characteristics were combined in various ways to simplify presentation of the data. Either the median scale value or the combination which gave the most significant statistical differences in later comparisons was used. The data is presented in percentages for clarity. Unless otherwise specifically stated, percentages are of the total sample throughout the study.

Marital status. The sample was almost equally divided between those who were married (49%) and those who were single (42%) or widowed (9%). Of those who were married, 59% had one or more children. (Figure 1)

Of the Canadian head nurses working in hospitals in 1967, 55% were married, 41% were single, and 4% reported another marital status.[6] Of the 653 registered nurses in British Columbia employed as head nurses or assistants in 1967, 54% were married, 32% were single, and 14% reported another status.[7] Figure 3 shows the marital status of these three groups. As there is no statistically significant difference, this comparison can be interpreted to mean that the sample is relatively representative of head nurses in Canada and in British Columbia in marital status.

Occupation of husbands. Blishen designed an occupational scale for workers based on socioeconomic and demographic data acquired from census information.[8] This scale ranks occupations from Class 1 for the professional group, to Class 7 for the unskilled laborer. The greater the skill required by an occupation, the higher its prestige, and the higher the social position of those in this occupation. According to this scale, almost a third of Canada's working population is in Class 5, which includes many skilled and semi-skilled trades. Graduate nurses are in Class 2. The occupations of husbands of the married respondents ranged from Class 2 to Class 7, with a median category of Class 4. (Figure 2) This category is below that of nurses but above that of the general Canadian population. Twenty-seven percent

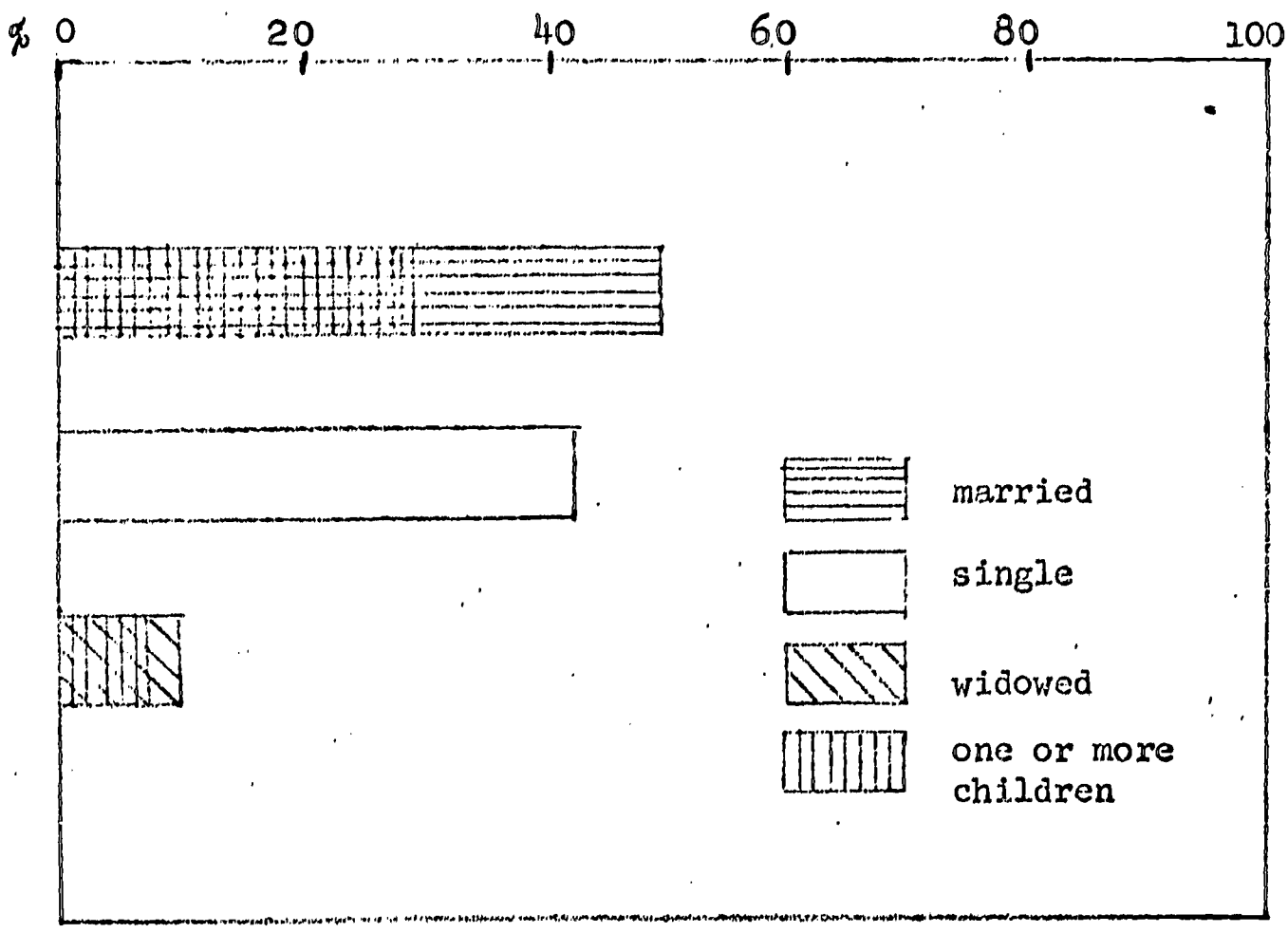

Fig. 1. Distribution of the sample by marital and parental status...

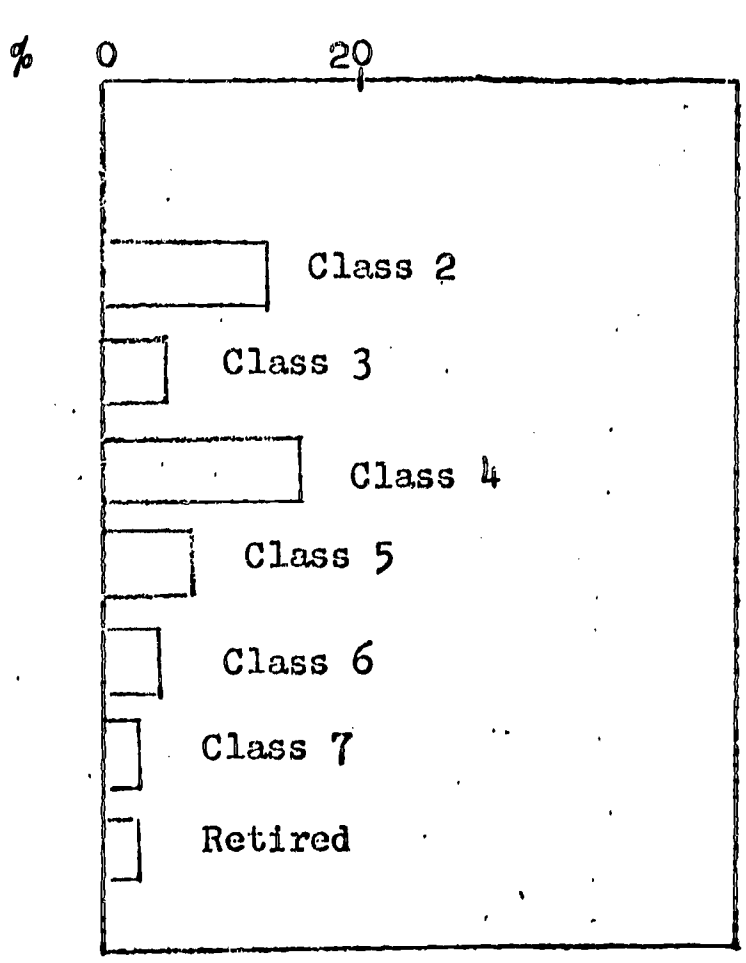

Fig. 2. Occupation of husbands on the Blishen Occupational Scale.

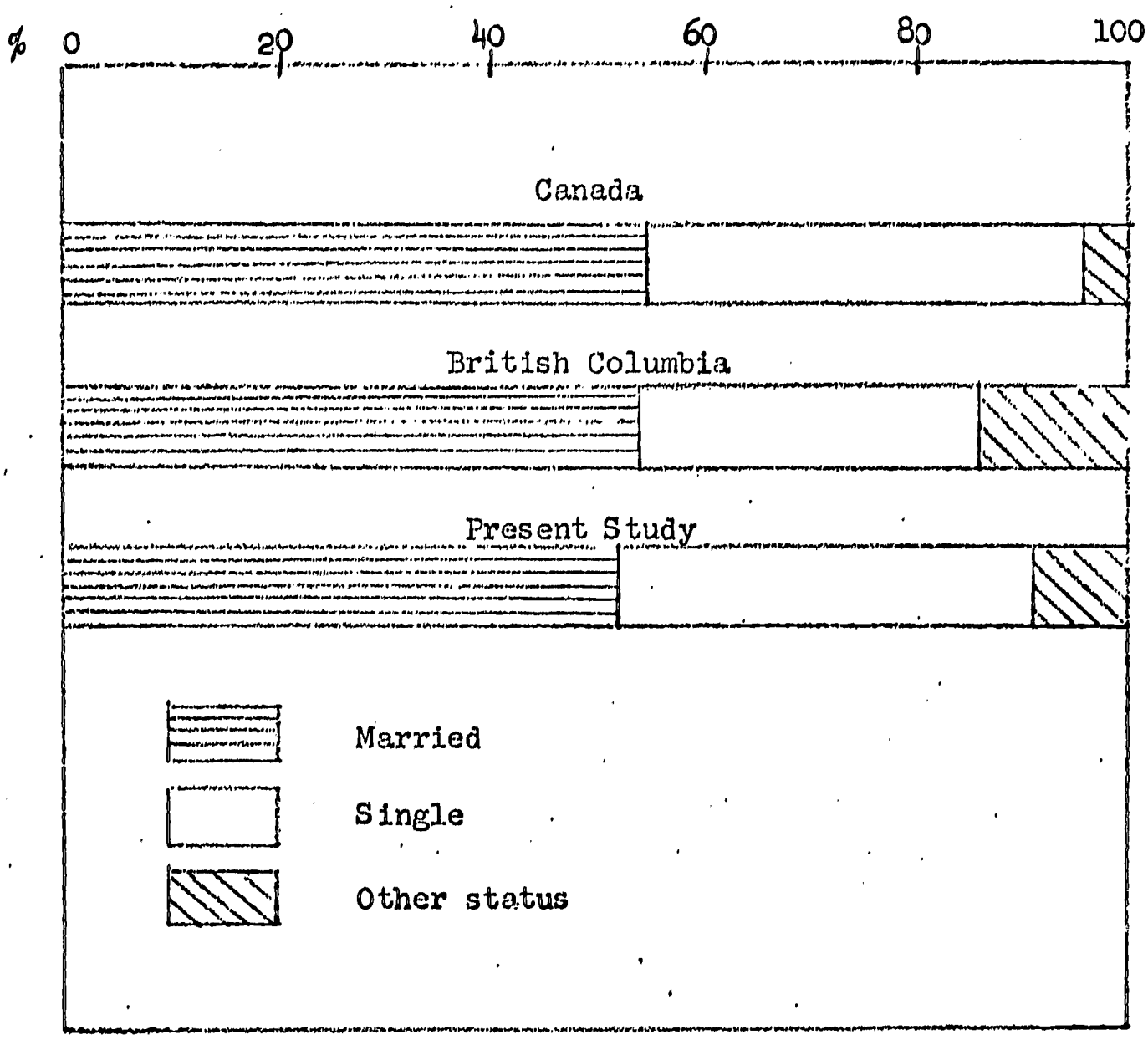

Fig. 3. Distribution of marital status of head nurses in Canada, British Columbia and the present study.

of the husbands were in the same occupational class as their wives.

Age. The age distribution of the sample ranged from one respondent under 25 years to three over 60 years, with the median category being 45 to 49 years. Of the sample, 51% were 45 years of age or over.

The age distribution of head nurses in British Columbia in 1967 ranged from less than 1% under 25 years to 7% over 65 years of age, with the median category being between 45 and 49 years.[9] Figure 4 depicts the age distribution of the provincial head nurses with those in the present study. As there is no statistically significant difference between the two groups, the sample is relatively representative of British Columbia head nurses with regard to age distribution.

Income. The gross annual income ranged from $5,000 to $8,999, with 80% receiving between $6,000 and $6,999 annually.

When the annual incomes of the respondents in the study are compared to the statistics for annual incomes for nurses in Canada and British Columbia, those in the study are average. As the British Columbia figures were a little higher (about $300 a year) than the Canadian figures, these nurses will now be well above the Canadian average income as contract changes in British Columbia in 1968 raised the basic annual income by almost $1,500.[10]

Social Participation. Chapin's Social Participation Scale measures the degree of a person's participation in community groups and institutions.[11] The extent of participation is measured by the number

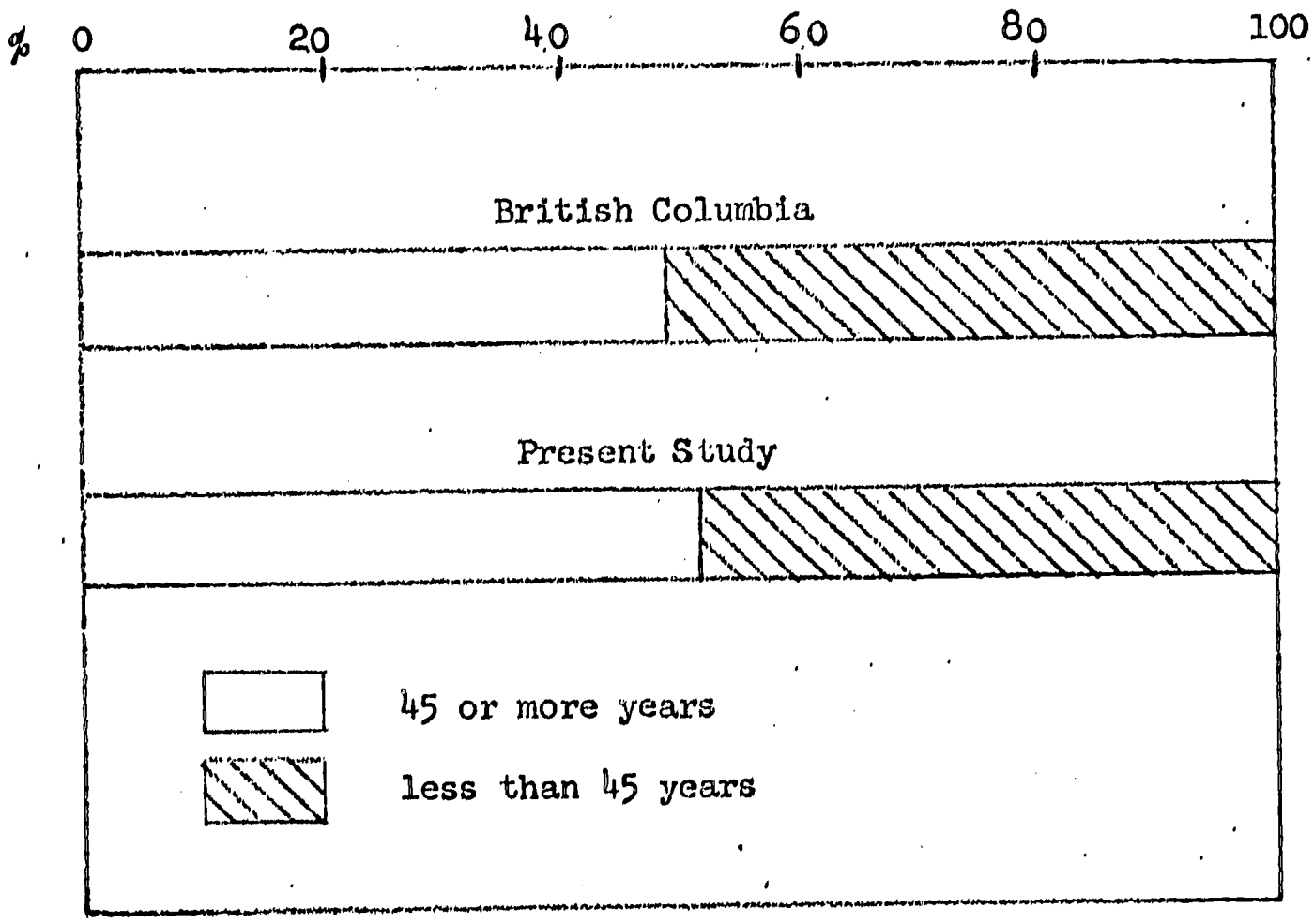

Fig. 4. Age distribution of head nurses in British Columbia and in the present study.

of memberships held during the previous year, and the intensity or degree of involvement is measured by attendance at meetings, financial contribution, committee memberships, and the holding of offices. Each of the component parts counts toward a rating on Chapin's Scale. The higher the rating, the greater the social participation of the person. The scores in the present study ranged from three to over thirty-five, with an average of sixteen. (Figure 5) Chapin states that the average score for professional and managerial occupational groups is 20, or four points above the study average.

Basic Academic Education. Seven percent of the sample completed two or more years of university education, 22% completed first year university, 64% graduated from high school and 7% did not finish high school. (Figure 6) Basic academic education for those entering a program of professional nursing education is controlled by law in all Canadian provinces, and requires a satisfactory standing in certain high school programs. Those in the sample with less than high school graduation entered schools of nursing before 1935, when amendments to required educational standards were made to the Registered Nurses Act. of British Columbia, originally passed in 1918.[12]

Non-nursing Education. Eleven percent of the respondents had taken business or secretarial training, and 16% had training in areas other than nursing following their basic academic education. Sixty-four percent had taken noncredit continuing education courses during the past five years and 87% hoped to do so in the future.

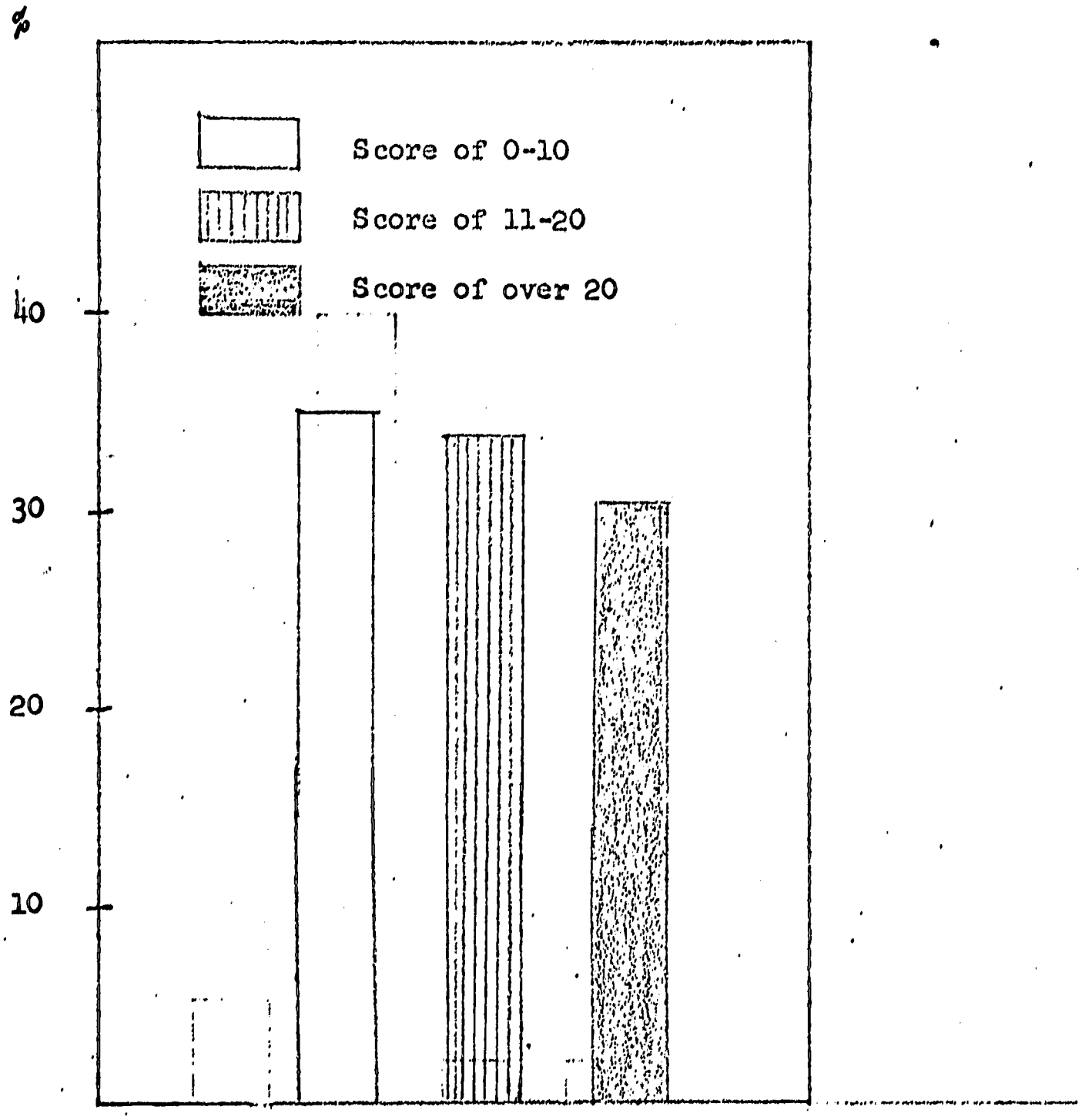

Fig. 5.. Distribution of the sample on Chapin's Social Participation Scale.

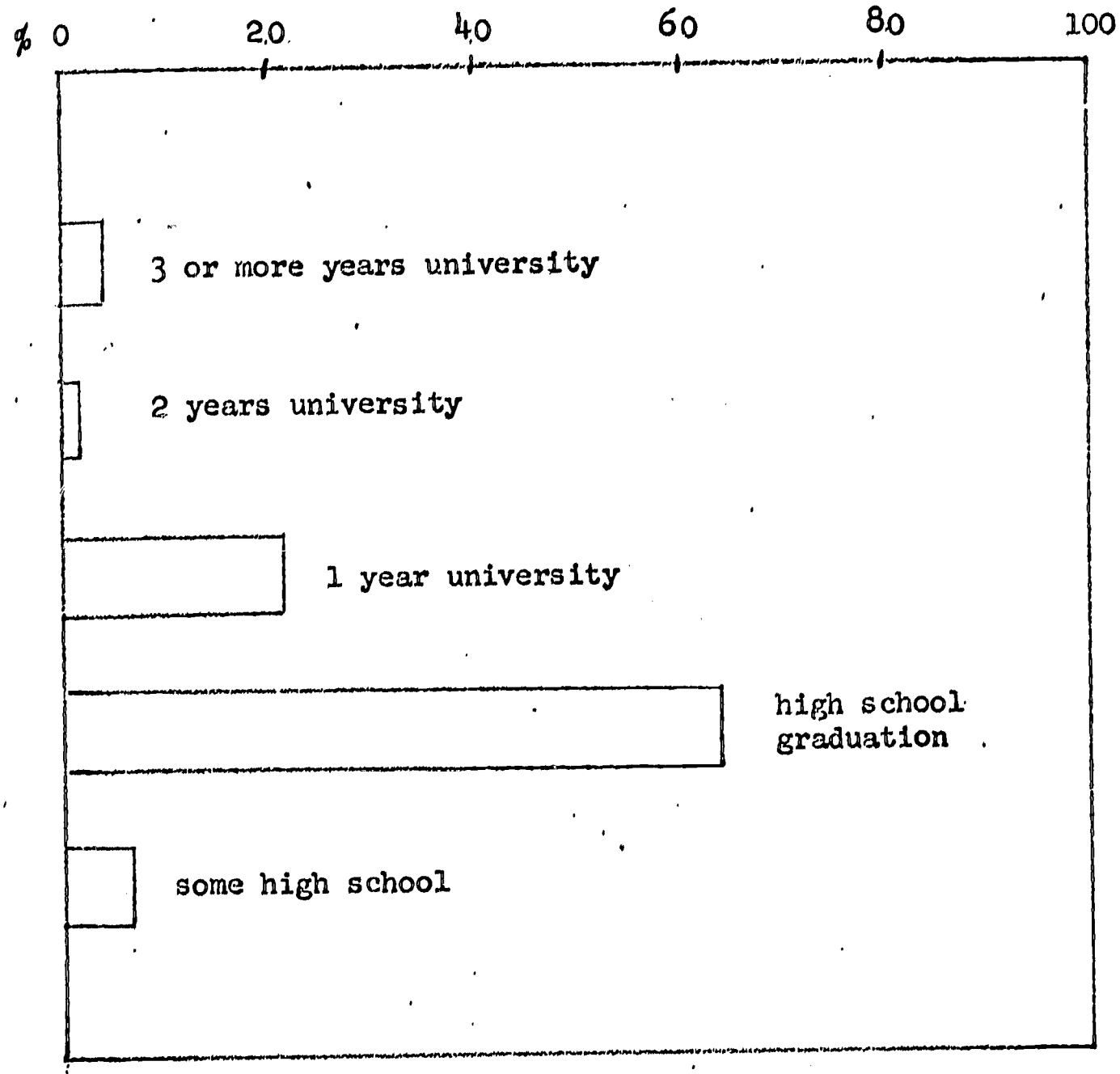

Fig. 6. Distribution of the sample by basic academic education.

Basic Nursing Education. Forty-seven percent of the respondents graduated from schools of nursing in British Columbia, 40% in other parts of Canada, and 13% in Great Britain. There were no graduates from other countries represented. The years of graduation ranged from 1930 to 1967, with 24% graduating before 1940, 33% between 1940 and 1949, 24% between 1950 and 1959, and 18% since 1960. All respondents graduated from general hospital schools of nursing.

Post Basic Nursing Education. Thirty-eight percent of the respondents had no post basic nursing education, 31% had completed the nursing unit administration course (Appendix A), 11% had completed a post graduate hospital clinical course, and 18% had at least one year of university nursing education. Only one respondent (2%) had a baccalaureate degree in nursing. (Figure 7)

A comparison of head nurses with and without at least one year of post basic university nursing education was made between Canadian statistics as listed in Countdown,[13] Campion's Study,[14] and the present study. (Figure 8) This comparison showed that 12% of Canadian head nurses, 16% of Campion's respondents and 20% of the present sample had one or more years of post basic university nursing education. As the differences were not significant, the study sample was relatively representative of Canadian head nurses, and comparable to the respondents in Campion's study regarding post basic university nursing education.

Campion's study[15] of nursing in Canada provided an interesting

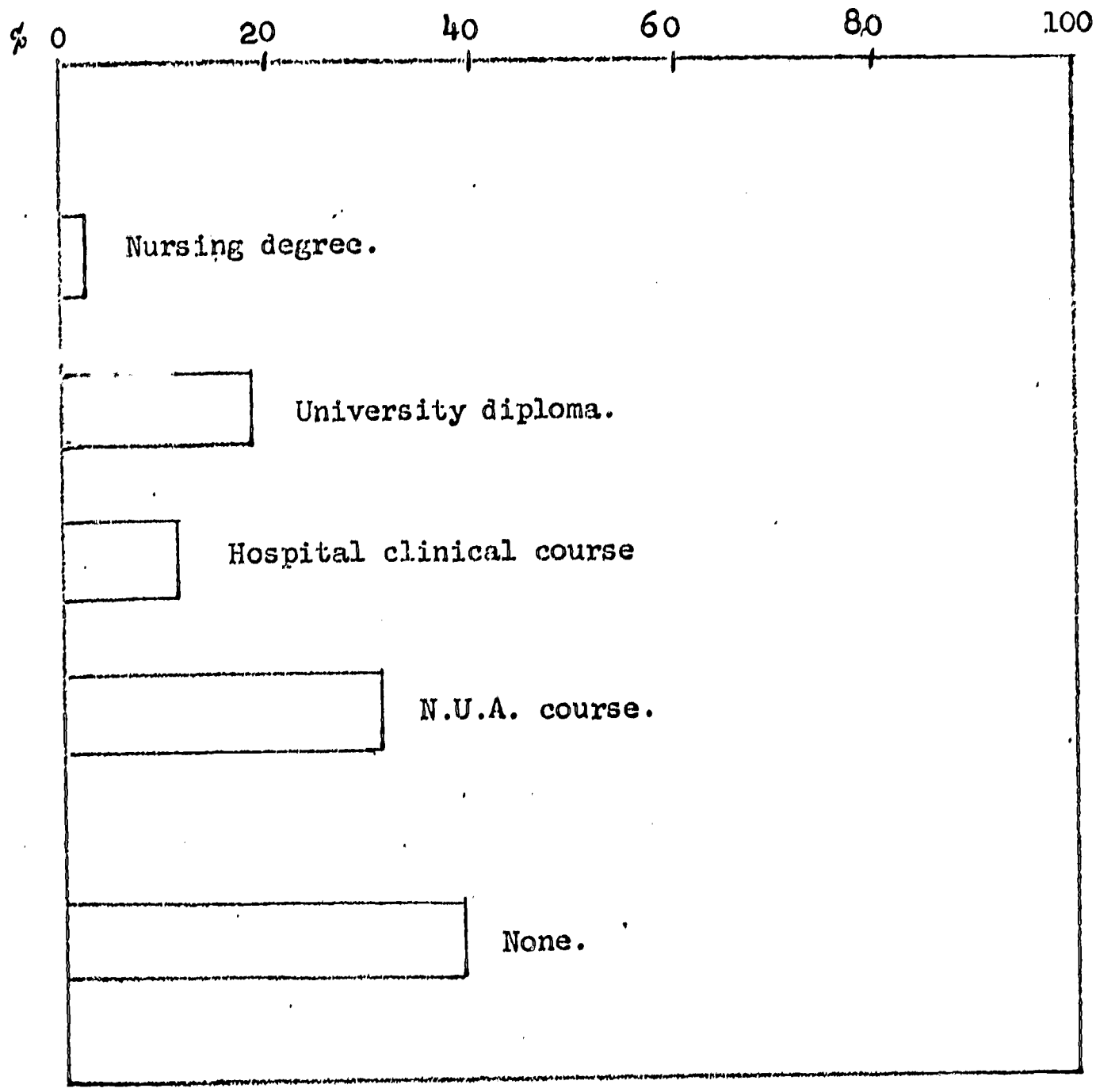

Fig. 7. Distribution of the sample by post basic nursing education.

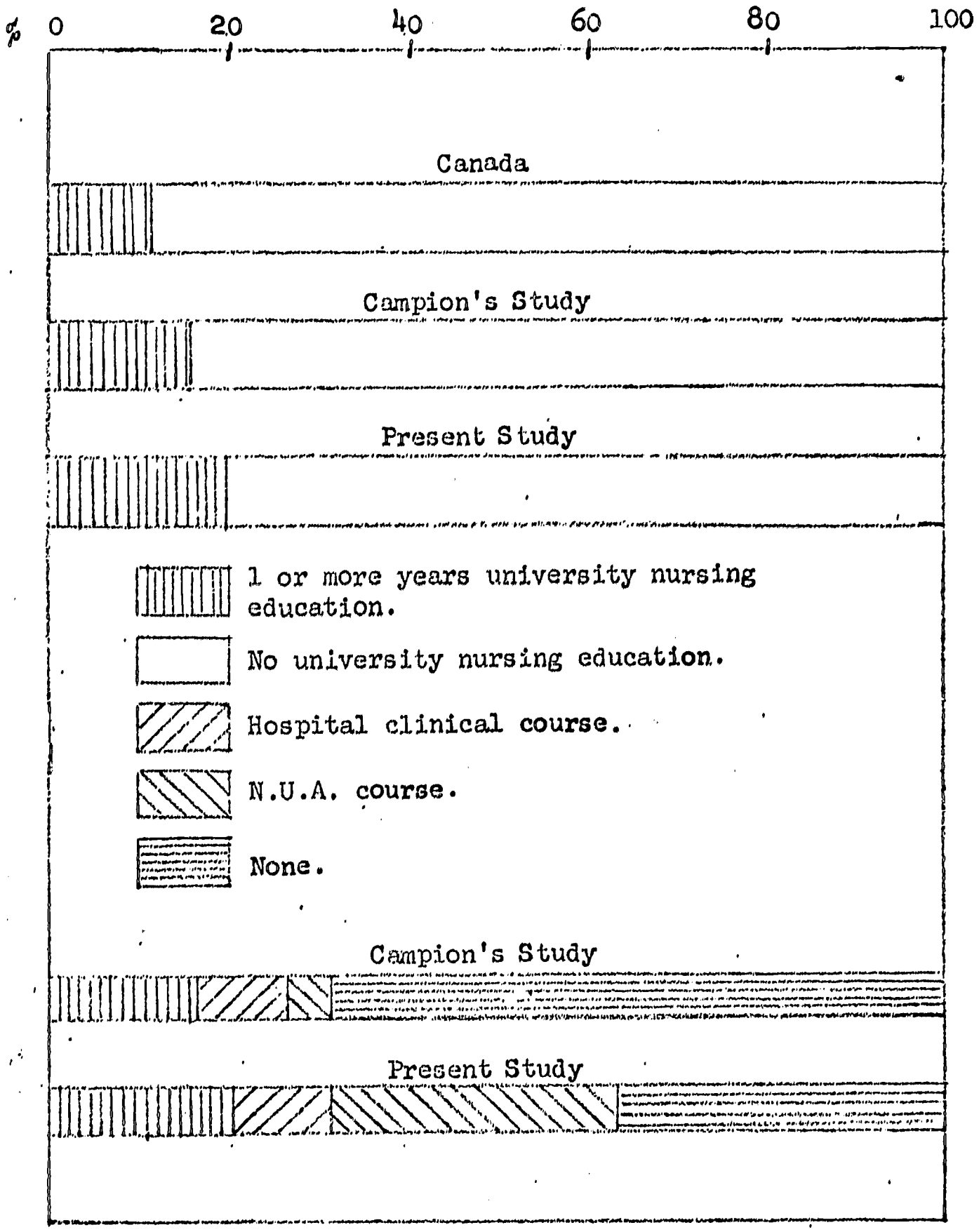

Fig. 8. Post Basic nursing education of head nurses in Canada, in Campion's study and in the present study.

set of statistics for comparison with data in the present study. Figure 8 shows that 69% and 38% of the respondents respectively had no post basic nursing education, 4% and 31% had completed the N.U.A. course (Appendix A), and 27% and 31% had completed a hospital clinical course or had at least one year of post basic university nursing education.

Why the correspondence course was so much more evident in the present study may be interpreted several ways. The differences might be due to the demand for education by nurses, the course being required for or strongly suggested by employing agencies to those unprepared for their head nurse positions, or a disproportionate number of past or current N.U.A. students being at the institutes because of their high interest. During the two years since publication of Campion's study, a larger percent of the sample had an opportunity to complete the course than in Campion's group. During 1967 and 1968, 12 of the study sample were students in the N.U.A. course. If these respondents were reallocated to the category of those with no post basic nursing education, the distribution would become 64% with no extra education, and 5% with the course, instead of 38% and 31% respectively. These new figures were not significantly different from those of Campion's study.

Other nursing courses, mostly clinical, had been taken by 18% of the sample during the previous five years.

Nursing and Head Nurse Experience. The respondents had

nursing experience which ranged from less than five years (7%) to over 35 years (4%). A total of 67% of the respondents had more than 15 years of nursing experience. (Figure 9) Fifty-six percent had five or more years experience as a head nurse. Only 11% of the respondents could be considered novices with less than a year of head nurse experience. (Figure 10)

Size of Employing Agency. Three of the respondents (7%) worked in health agencies other than hospitals, 53% worked in hospitals of less than 500 beds, and 40% worked in larger hospitals. (Figure 11)

Type and Size of Nursing Units. Sixty percent of the respondents worked in medical-surgical nursing units. Nine of the respondents (20%) worked in public health agencies or transient patient areas, 33% worked in units of less than 30 beds, and 47% worked in larger units. (Figure 12)

Size of Staff. Thirty-eight percent were responsible for personnel numbering less than fifteen, and 62% were responsible for more. (Figure 13) The head nurse was responsible for the supervision and evaluation of these staff members unless her supervisor did the reports and/or the interviews. Student nurses were included in a few cases, and the head nurse assisted the instructor in doing the reports or did them herself.

Perception of the Institute. One only answer was elicited from each respondent on the Kropp Verner Attitude Scale (Appendix D)

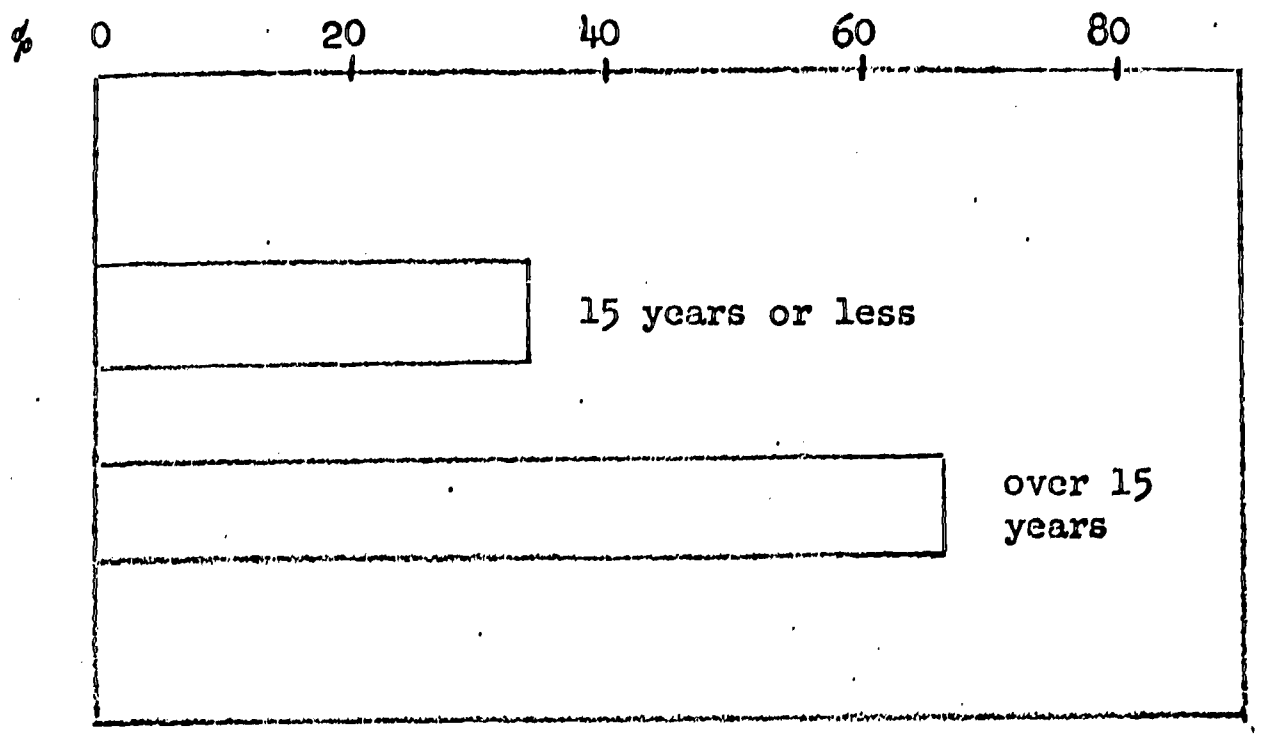

Fig. 9. Distribution of the sample by years of nursing experience.

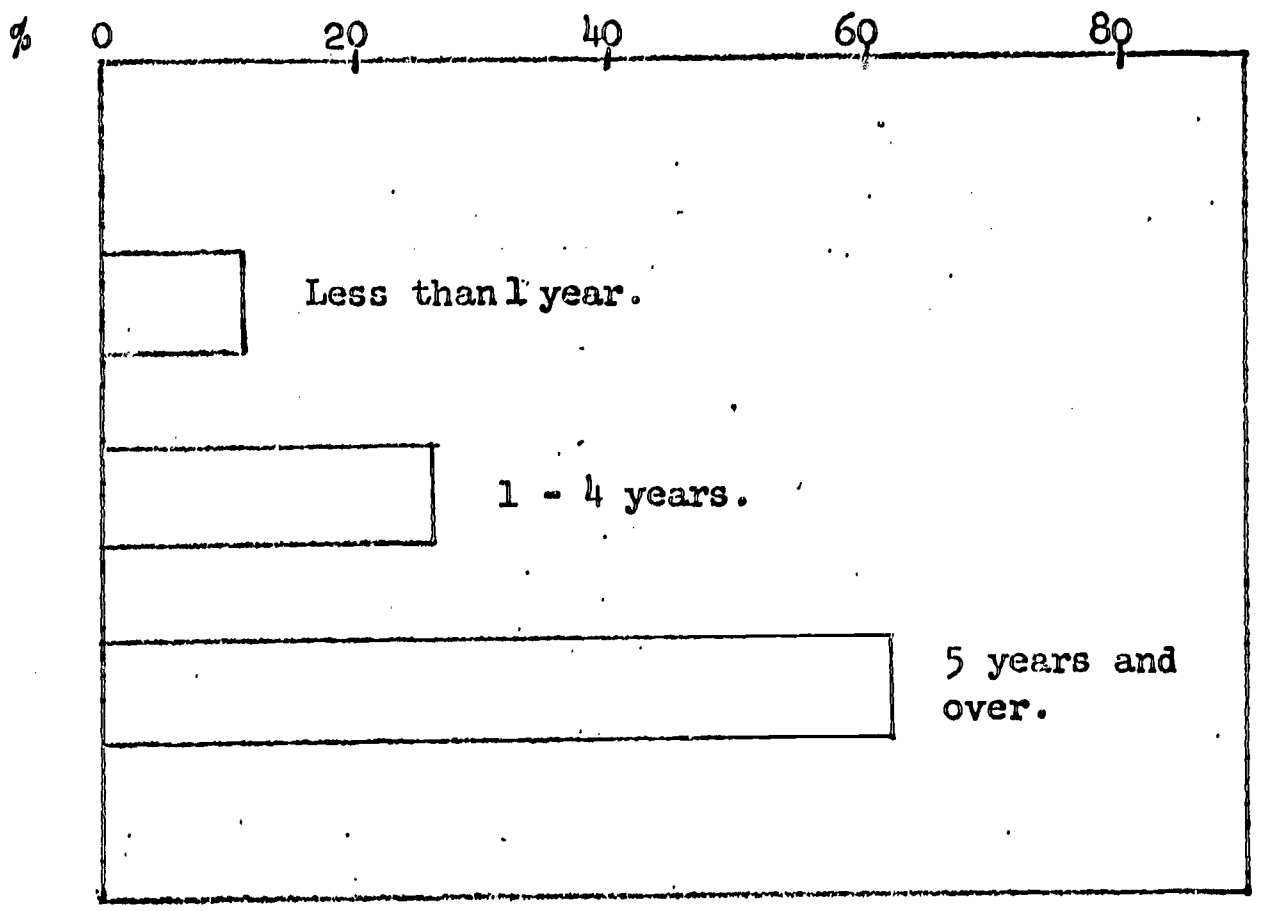

Fig. 10. Distribution of the sample by years of head nurse experience.

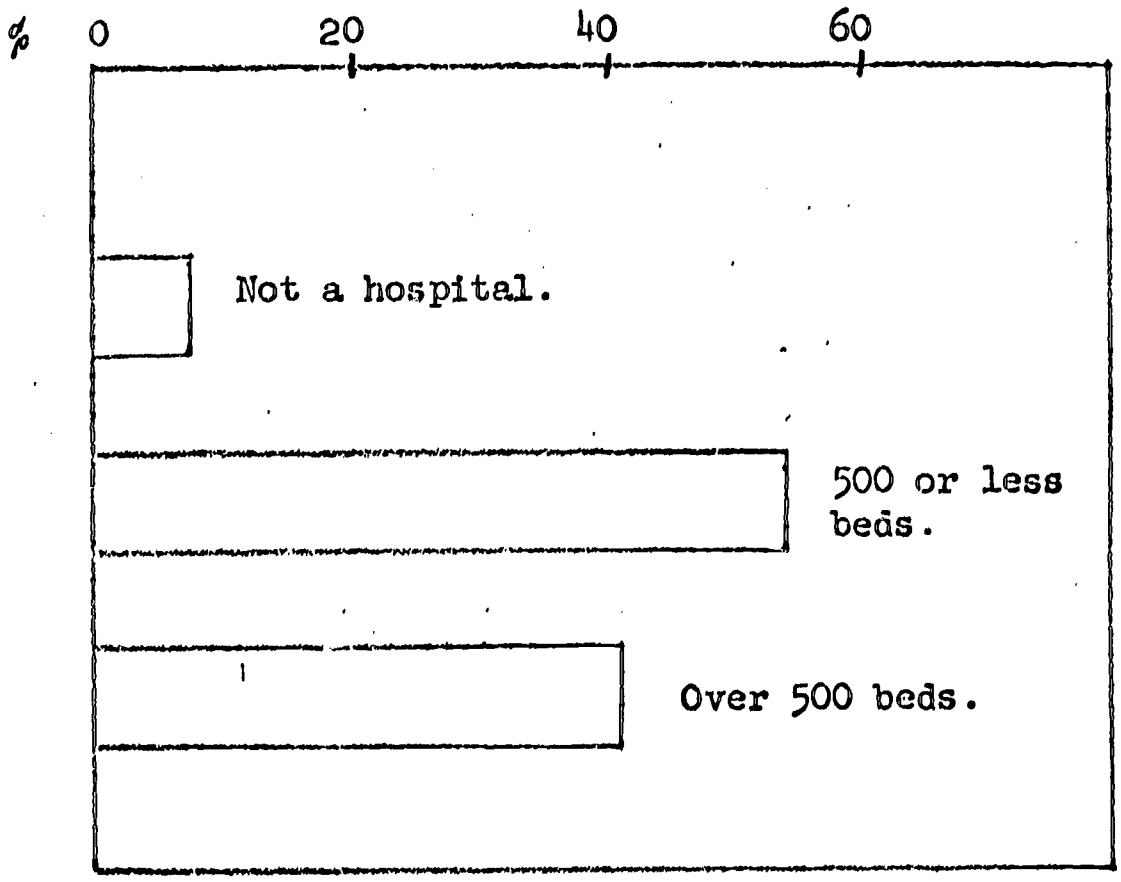

Fig. 11. Distribution of the sample by size of employing agency.

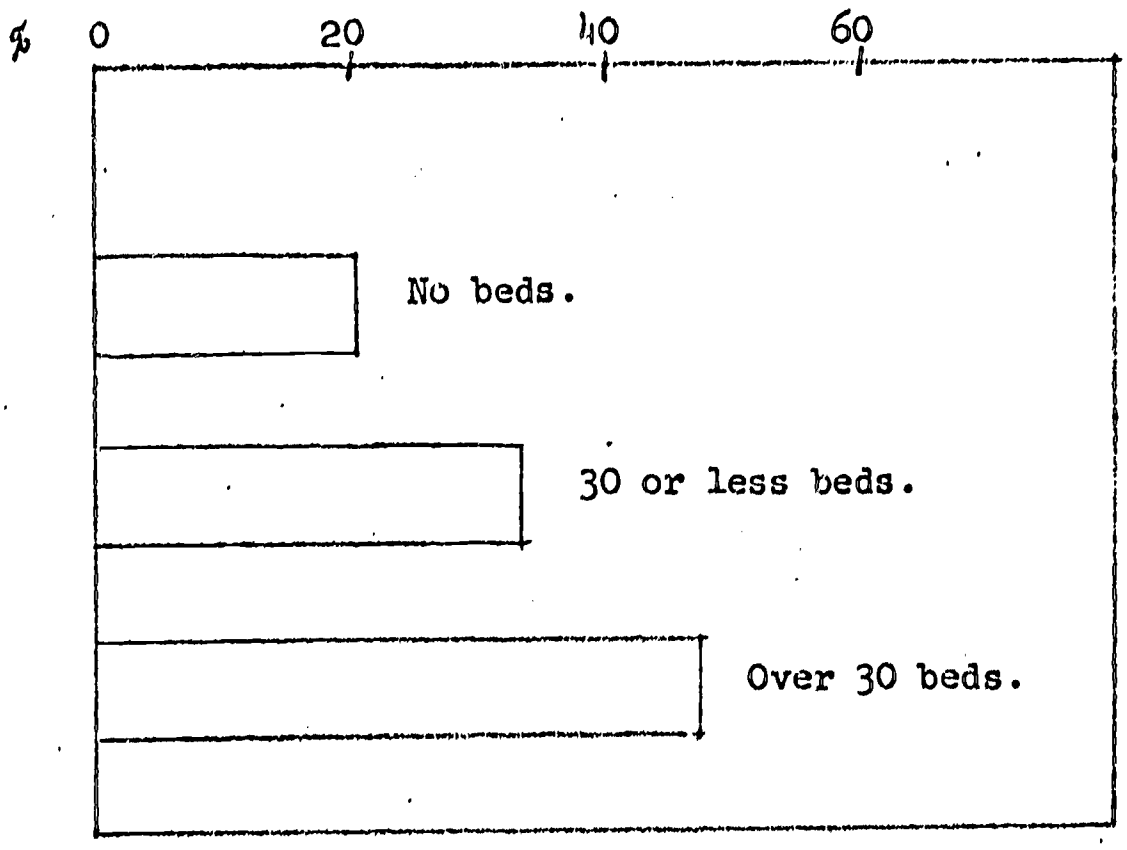

Fig. 12. Distribution of the sample by size of nursing unit.

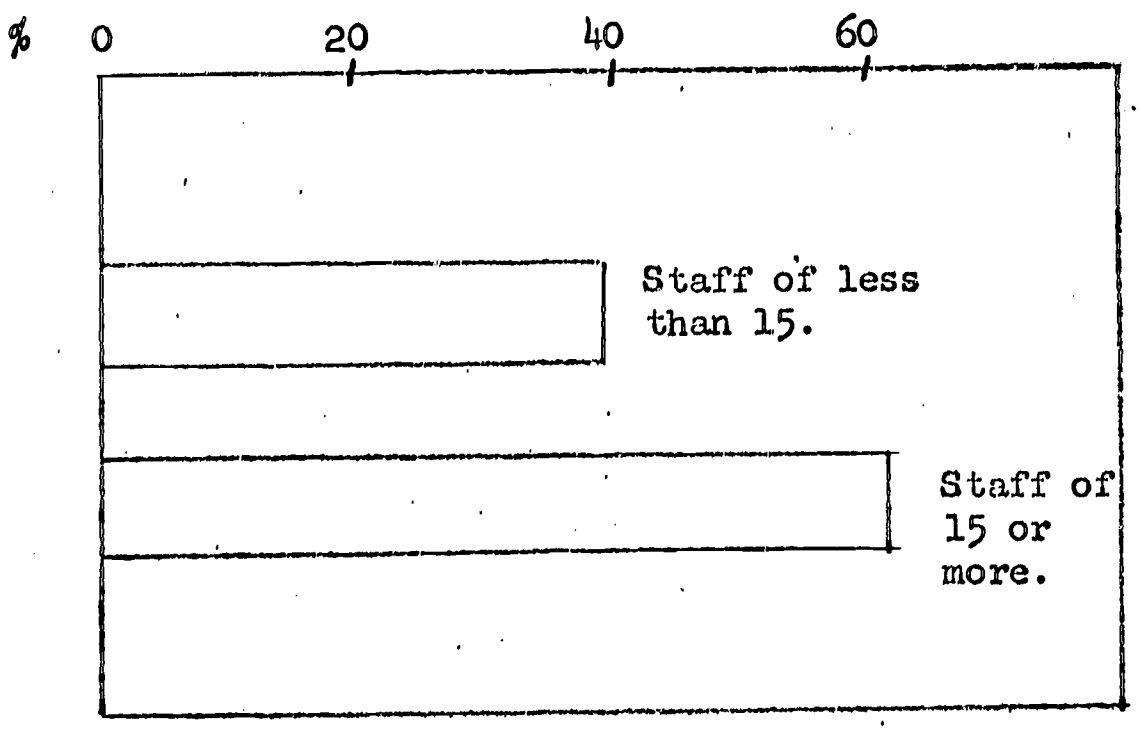

Fig. 13. Distribution of the sample by size of staff.

which measures the general attitude of the respondent toward an organized educational experience.[16] The median rating for all respondents was Item 5, "It helped me personally." The ratings are shown in Figure 14.

Comparison of Background Categories

The various combinations of each background category were compared with one another. These comparisons were originally done on punch cards and later verified on a computer. A probability of .05 was chosen as the level of significance, calculated with the chi square test when the observed frequency was over five, and with the Kolomogorov-Smirnov test when the observed frequency was smaller.[17] All figures showing comparisons in the text and in the graphs are at this level or better, unless otherwise indicated.[18] Ten percent of the sample, or 4.5 individuals, was a very small frequency for the statistical treatment of observed variations, however.[19] (see Tables I and II, p. 52 and 53)

Of the 841 tables which resulted from these comparisons 21 showed differences at or above the chosen level of significance. Some of these added nothing meaningful to the results of the study. For example, of those with over 15 years of nursing experience, 73% were over 45 years of age, and 73% had been head nurses for over five years. Of those with less than 15 years of nursing experience, 7% were over 45 years of age, and 20% had been head nurses for over five years. (Figure 15)

Of the married respondents, 86% had high school graduation or less, 41% had been head nurses for 5 or more years, and 82% were responsible for staffs of 15 or more people. Of the unmarried

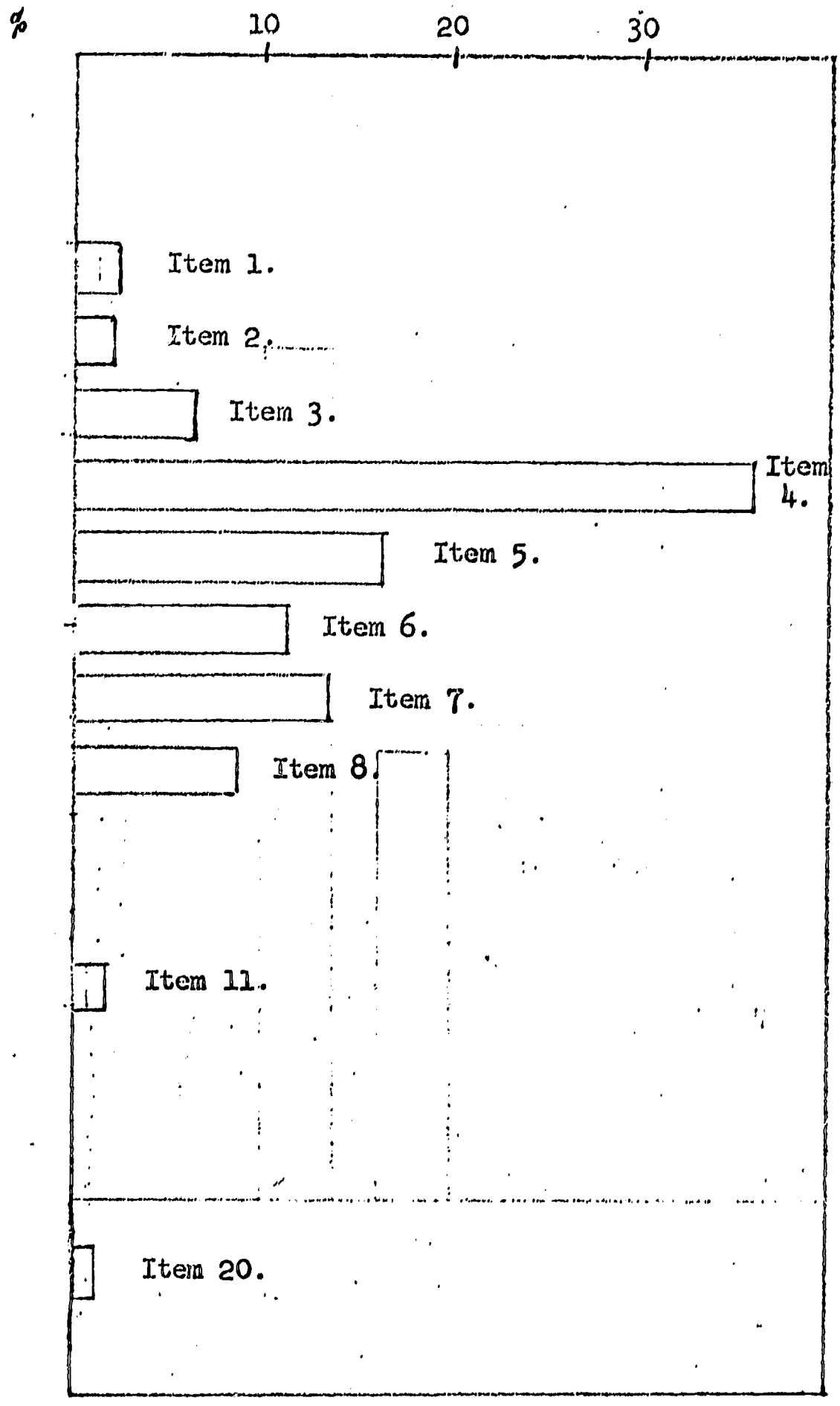

Fig. 14. Distribution of the sample by rating on the Kropp Verner Attitude Scale.

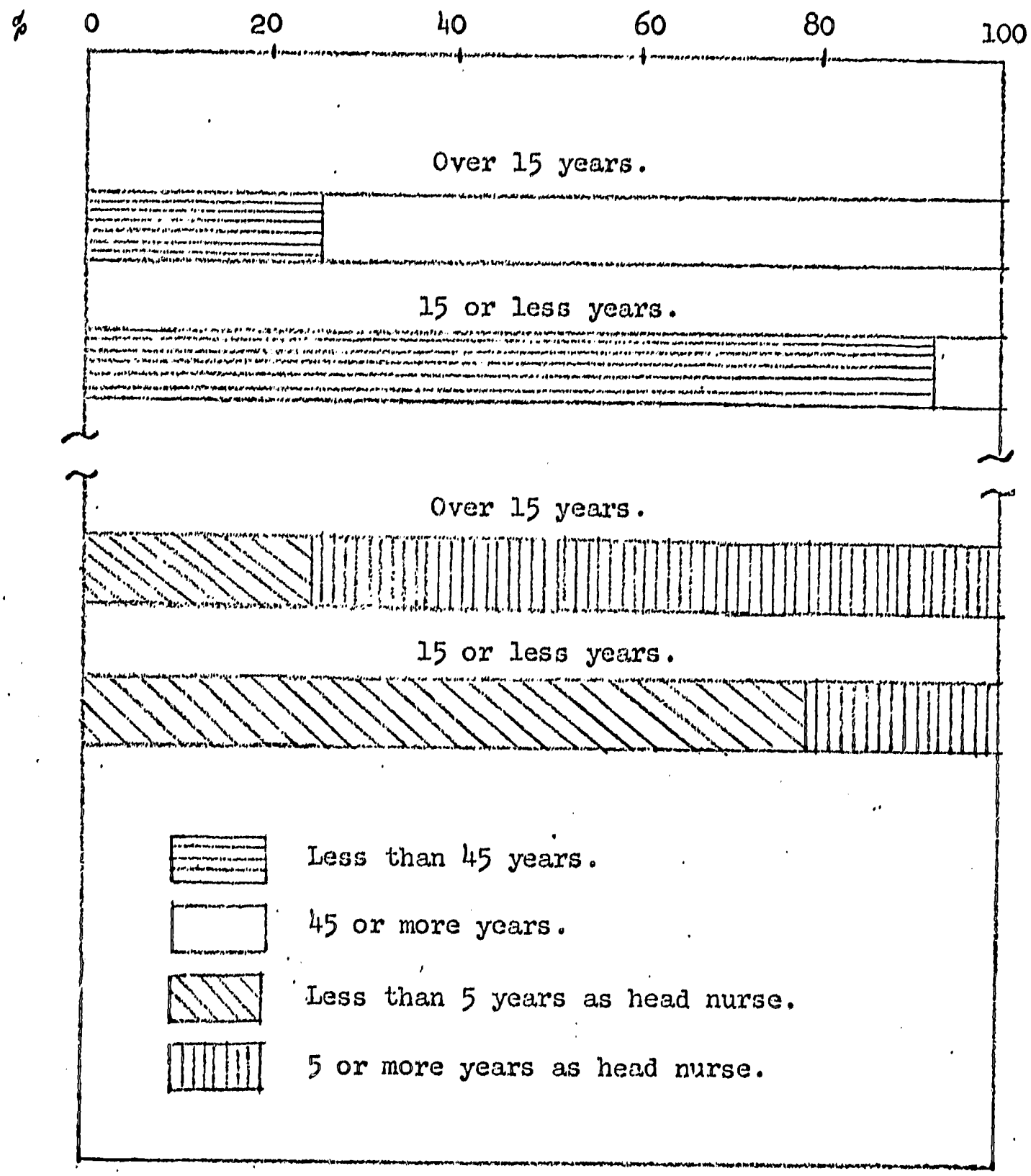

Fig. 15. Years of nursing experience related to significant background categories: age, and head nurse experience.

respondents, 57% had high school graduation or less, 70% had been head nurses for 5 or more years, and 43% were responsible for staffs of 15 or more people. (Figure 16) What these differences mean is difficult to determine. The differences in basic academic education may mean that the two groups had different career goals, or that the unmarried group achieved further education later. At the time of the interviews, the respondents were not asked for details regarding their education, other than how much they had completed. The difference could show a trend toward career orientations for those who remain in nursing. The difference in the number of each group who had been head nurses for over five years would be accounted for by fewer of the more experienced group being married. The responsibility for large staffs is an interesting difference. Whether those who remain in nursing gradually take over smaller nursing units, and therefore smaller staffs, or whether they become charge nurses in more specialized areas, again with smaller staffs, is problematical.

Of those under 45 years of age, 18% had completed the N.U.A. course, and 27% had other post basic nursing education; 77% were responsible for staffs of 15 or more. Of those over 45 years of age, 43% had completed the N.U.A. course, and 37% had other post basic nursing education; 48% were responsible for staffs of 15 or more. (Figure 17) As would be surmized, there were significant differences with the year of graduation, years of nursing experience, and years as a head nurse. Those who were older had more nursing education than the younger group, possibly because of the career and time differences. The

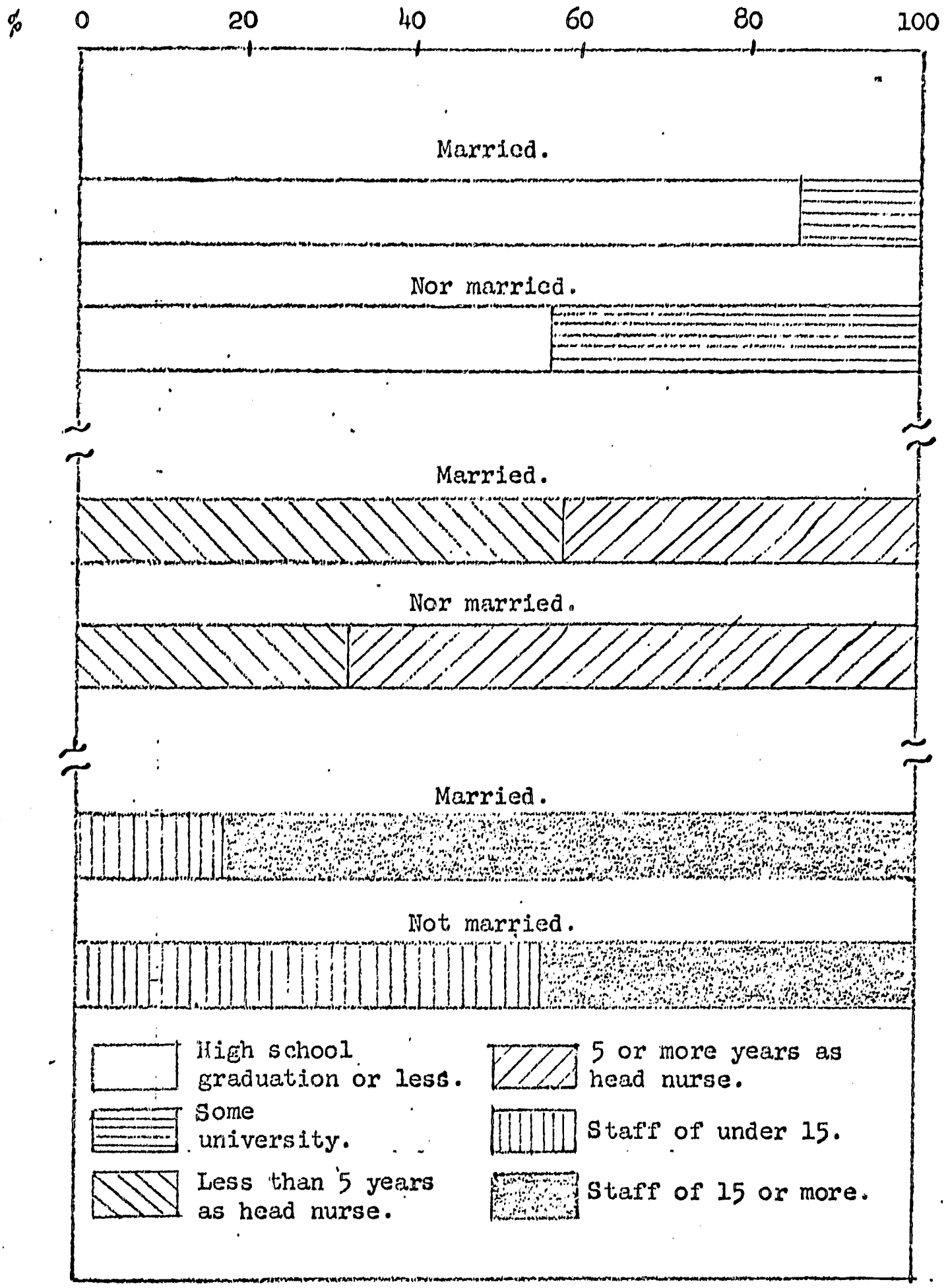

Fig. 16. Marital status related to significant background categories: post basic nursing education, years of head nurse experience and size of staff.

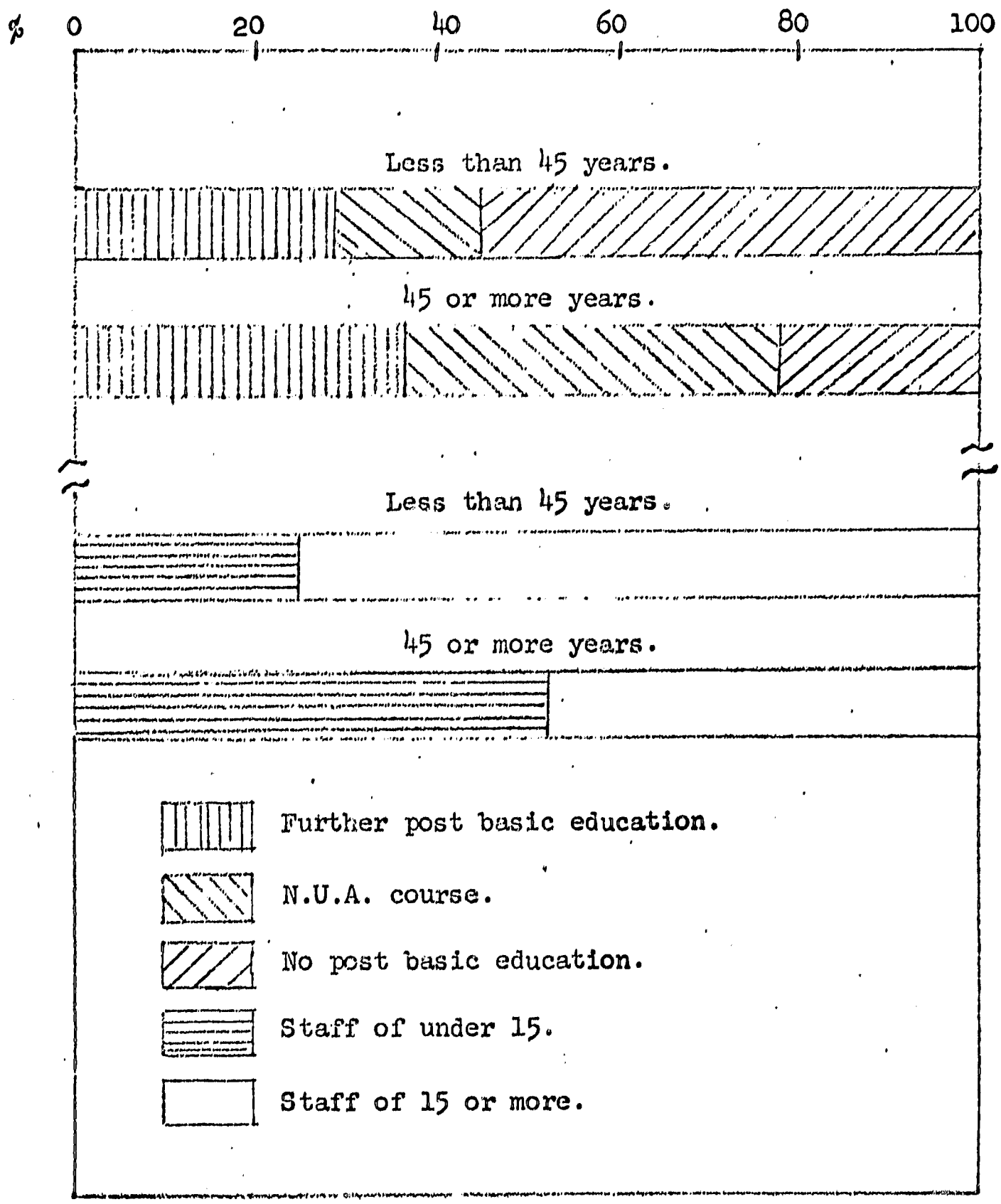

Fig. 17. Age related to significant background categories: post basic nursing education and size of staff.

differences in size of staff were commented on earlier with regard to those who were not married.

Of those with a score below the median of 11 on the Chapin scale, 32% graduated from nursing schools after 1950, 82% had more than 15 years of nursing experience; and 32% were responsible for nursing units of over 30 beds. Of those with a score over the median, 52% graduated from nursing schools after 1950, 52% had more than 15 years of nursing experience, and 61% were responsible for nursing units of over 30 beds. Although these scores appear to be confusing, the trend seems to be that the older more experienced nurses were among the lower scorers, and the younger less experienced nurses were among the higher scorers. This is not surprising when the societal trend is for younger adults, married or nonmarried, to be participants in community activities.

Of those who had high school graduation or less, 41% were not married. Of those with more than high school graduation, 77% were not married. (Figure 18) It was mentioned earlier that career goals would probably differ between those who were married and those who were not. Again, time of education was not elucidated at the time of the interviews. The relationship between years of education and marital status could not be determined from these data.

Of those with no post basic nursing education, 71% were under 45 years of age, and 59% were employed in smaller hospitals. Of those who had completed the N.U.A. course, 29% were under 45, and 43% were employed in smaller hospitals. Of those who had further nursing

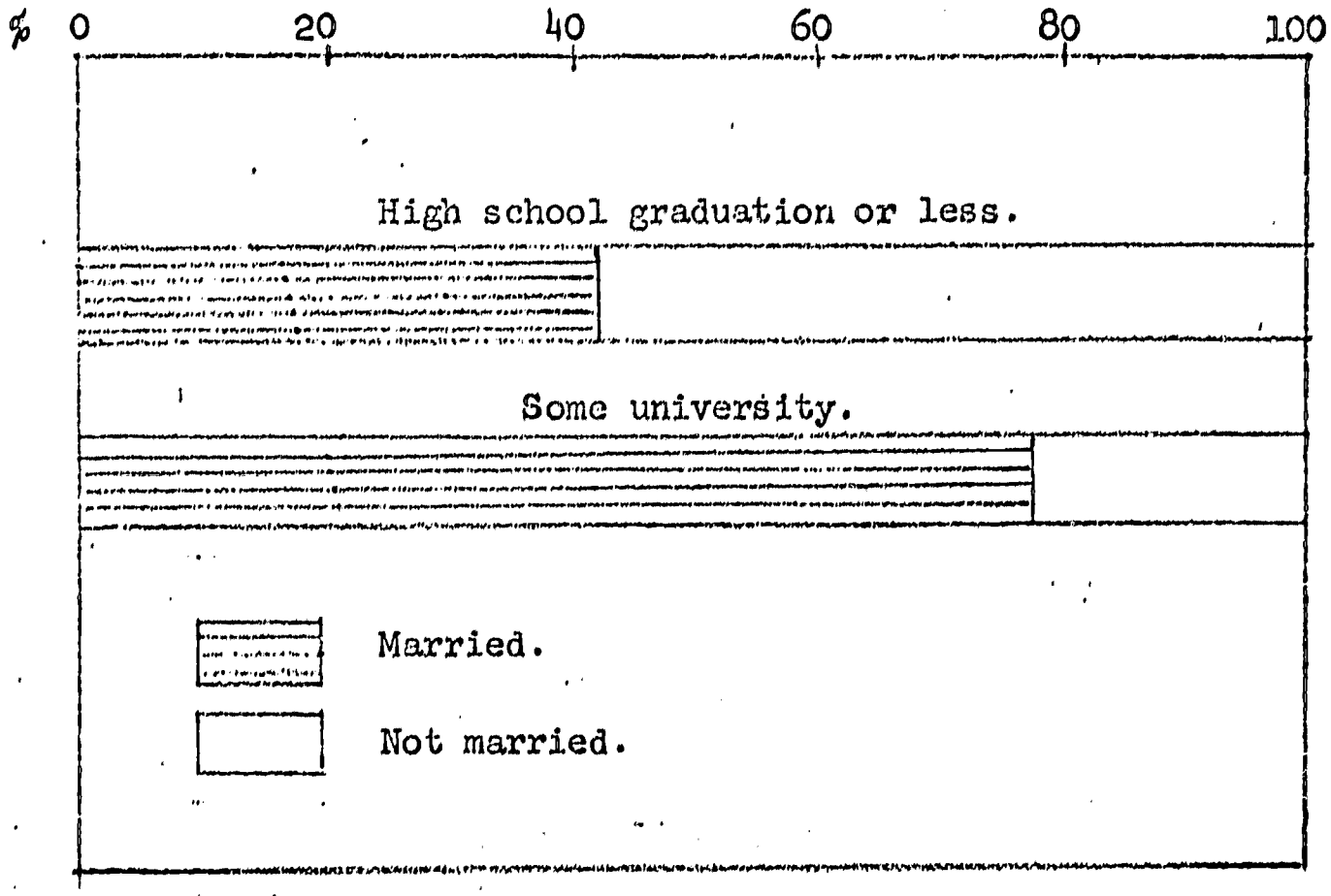

Fig. 18. Basic academic education related to significant background categories: marital status.

education, 57% were under 45, and 79% were employed in smaller hospitals. (Figure 19) These differences indicated that those over 45 years of age have, on the whole, advanced their education, particularly through the N.U.A. course. University courses may not have been feasible because the lack of incentive, low academic records, fear of attempting anything so unknown, or financial limitations. Those with no post basic education and those with further nursing education were both found more frequently in smaller hospitals. The 7% in the public health agencies would have skewed the results in the group with more nursing education, but not significantly. Geographic distribution would be controlled to some extent by the marital status of the nurse, and, for those married, by the location of the husband's place of work, but marital status was not significantly different for those working in smaller hospitals.

Of those with less than five years of experience as a head nurse, 35% were not married, 30% were over 45 years of age, 40% had more than 15 years of nursing experience, and 85% were responsible for staffs of over 15. Of those with five or more years of head nurse experience, 64% were not married, 68% were over 45 years of age, 88% had more than 15 years of nursing experience, and 44% were responsible for staffs of over 15. (Figure 20) Almost double the number of those with less experience in nursing and as head nurses were in charge of larger staffs than were more experienced head nurses. This was mentioned earlier regarding marital status.

Of those in smaller hospitals, 37% had no post basic nursing education, 22% had completed the N.U.A. course, and 41% had further

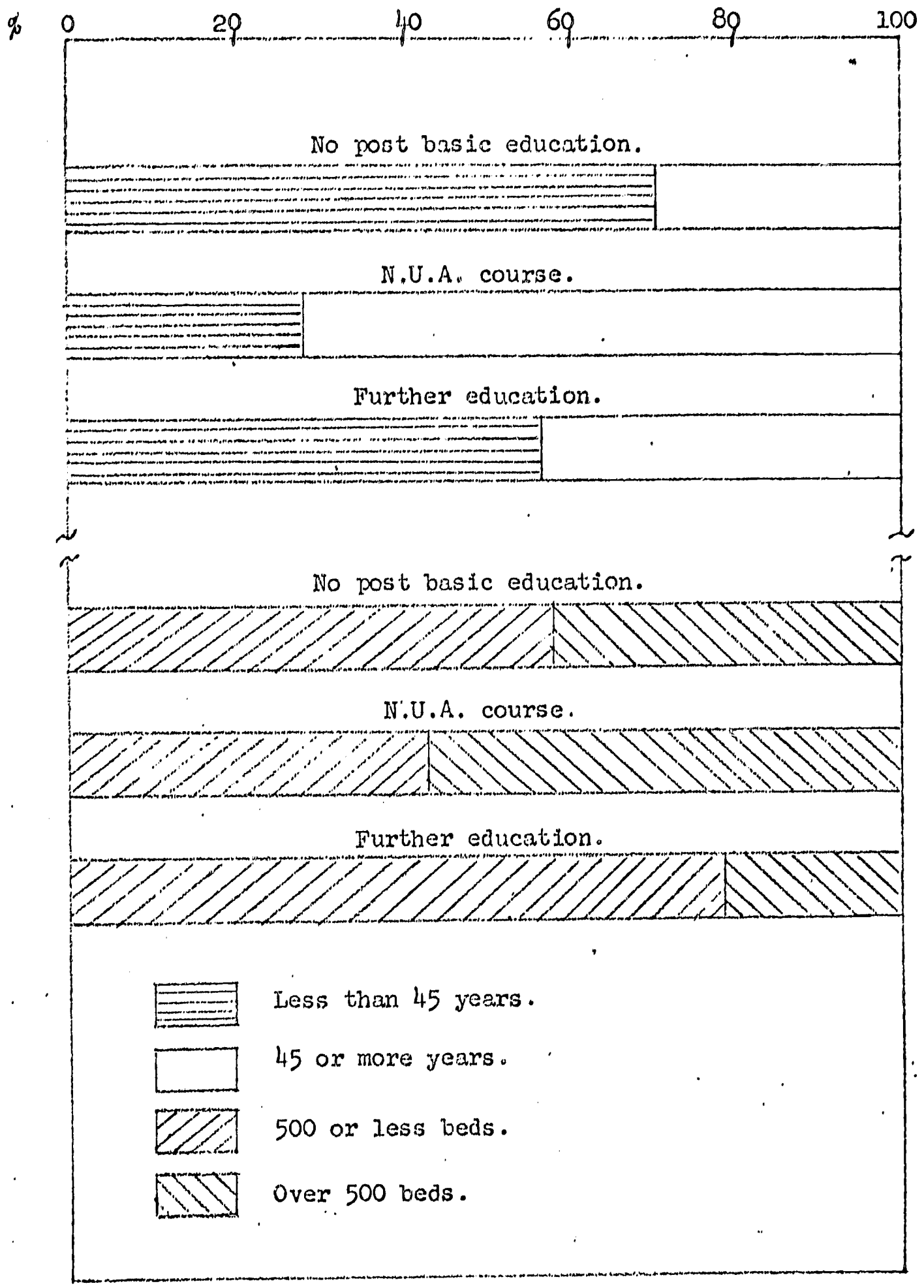

Fig. 19. Post basic nursing education related to significant background categories: age and size of employing agency.

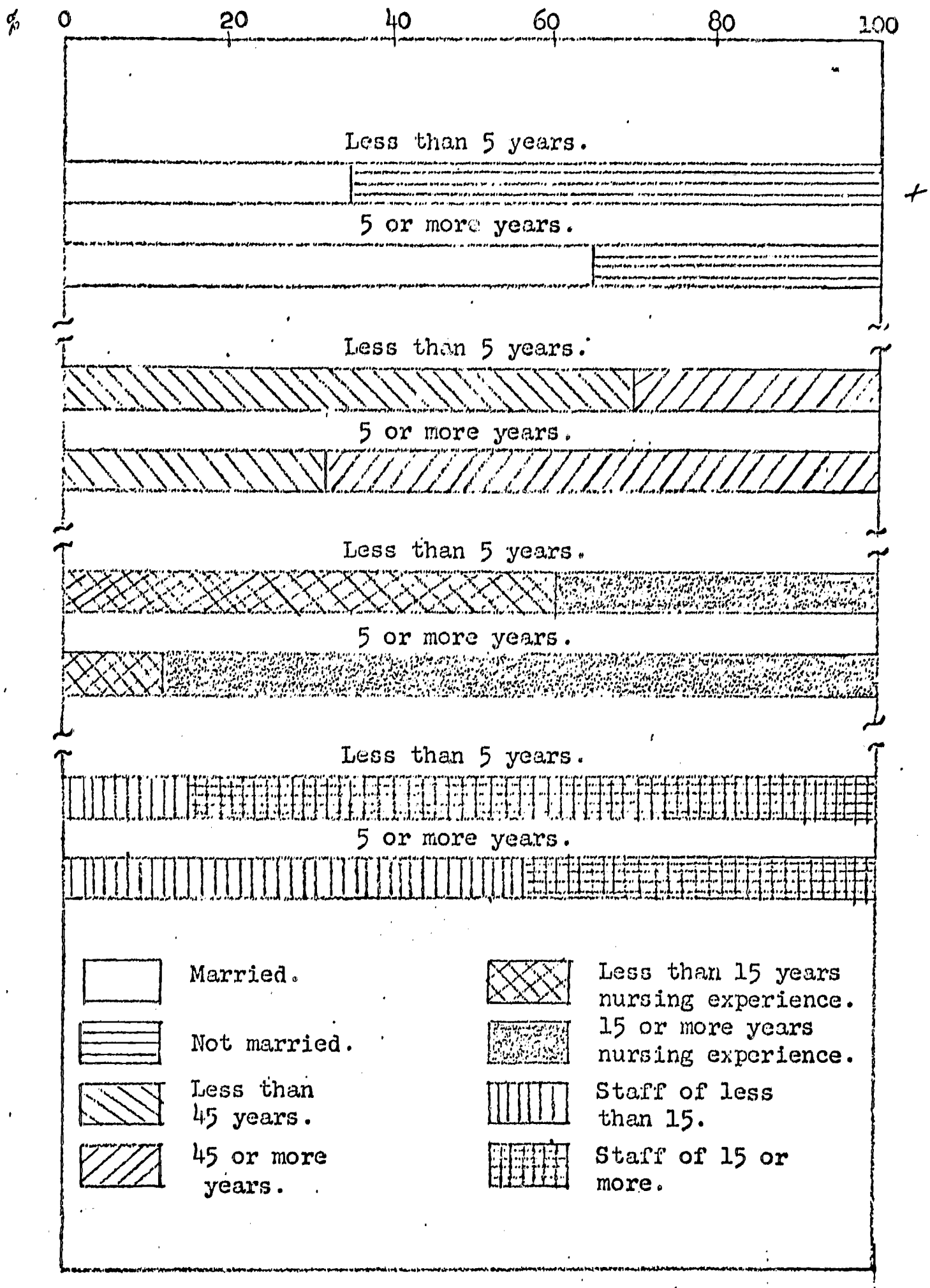

Fig. 20. Years of head nurse experience related to significant background categories: marital status, age, nursing experience and size of staff.

nursing education. Of those in larger hospitals, 39% had no post basic nursing education, 44% had completed the N.U.A. course, and 17% had further nursing education. (Figure 21) The almost equal ratio of those with no post basic nursing education in smaller and larger agencies raises various speculations. The ratio could result from a habitual staffing pattern in the agencies, or from the situation relative to those available in the community for employment by the hospital.

The ratios of those with further education differs between smaller and larger hospitals. This could result from the type of course instigated by the agency, insisted upon by the agency, or allowed through leave of absence or payment by the agency. The individual at the bottom in a large institution perceives opportunity for personal advancement, and will therefore often be internally motivated toward more education. The staff turnover is greater in the larger hospitals also, which increases the hope of advancement but also the fear of dismissal. The reasons for the N.U.A. course in preference to, or instead of, university programs were discussed earlier.

Summary

In this sample which is representative of head nurses in the population chosen, and in British Columbia and Canada in some areas, there is no profile of the typical head nurse which is apparent. There is no concentration of any specific characteristic in the sample. The significant statistical differences are given in Tables 1 and 2 in percentages.

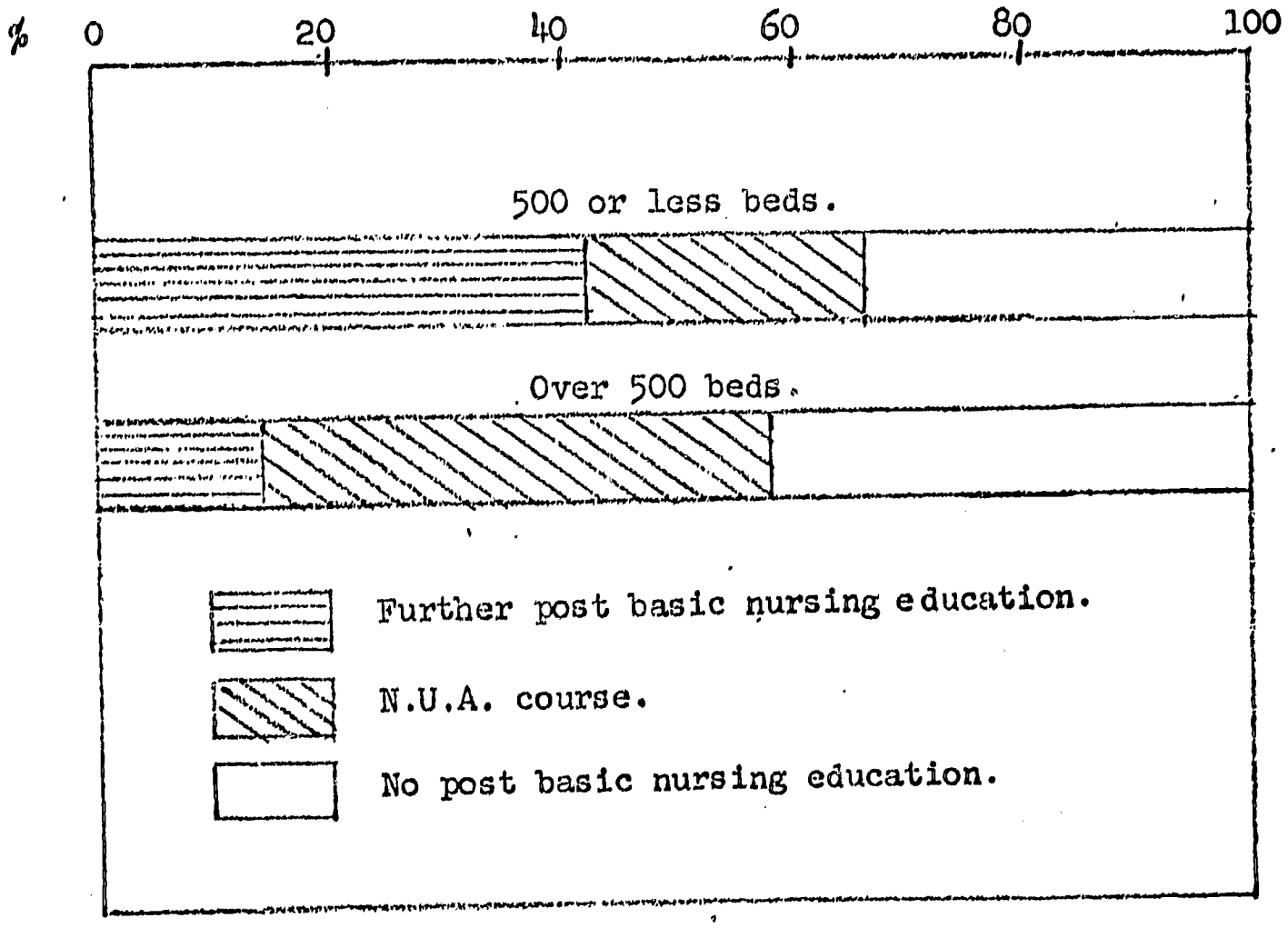

Fig. 21 Size of employing agency related to significant background categories: p post basic nursing education.

TABLE I. Comparison of background categories.

(all figures are percent)

		Agency size (beds)				Head nurse (years)				Post basic nursing education				Basic education				Chapin Scale				Age				Marital Status			
		500 plus		500 minus		5 plus		5 minus		further		N.U.A. course		none		some university		H.S. graduation		11 plus		11 minus		45 plus		45 minus		married		not married	
Marital Status	married																	59											
	not married																	41											
Age	45 minus																									71		29	
	45 plus																									29		71	
Basic Academic Education	H.S. graduation	86		57																									
	some university	14		43																									
Year of graduation	before 1950																												
	after 1950																												
Post basic nursing education	none																												
	N.U.A. course																												
	further																												

TABLE II. Comparison of background categories.

(all figures are percent)

		Marital Status		Age		Chapin Scale		Basic nursing education			Post basic nursing education		Head nurse (years)		Agency size (beds)	
		married	not married	45 plus	45 minus	11 plus	11 minus	some university	H.S. graduation	none	further	N.U.A. course	5 plus	5 minus	500 plus	500 minus
Nursing experience (years)	15 minus					82	52						40	88		
	15 plus					18	48						60	12		
Head nurse (years)	5 minus	59	30													
	5 plus	41	70													
Agency size (beds)	500 minus															
	500 plus															
Unit size (beds)	30 minus					68	39									
	30 plus					32	61									
Staff size (number)	15 minus	18	57	23	52								15	56		
	15 plus	82	43	77	48								85	44		

Footnote References

1. Edwards, A.L. Statistical Analysis. New York. Rinehart. 1959. pp. 192-196.

2. A random selection from alphabetical listings of an incomplete (approximately four-fifths) population could conceivable skew the results. However, when compared with information available from Countdown (6) and Provincial Inventory (7), the socioeconomic data collected revealed that the sample chosen was representative of head nurses in Canada and/or British Columbia regarding marital status, age distribution, income, and post basic nursing education. Therefore, neither the alphabetical listing nor the geographic limitations skewed the results.

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4. Chapin, F.S. Chapin's Social Participation Scale. 1952 Edition. In: D.C. Miller. Handbook of Research and Social Measurement. New York. McKay. Social Science Series. 1964.

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6. Canadian Nurses Association. Countdown 1968. Ottawa. 1968. p. 15.

7. Provincial Inventory of Nurses. British Columbia. 1967. Research Unit. Ottawa. Canadian Nurses Association. May, 1968. Table 7.

8. Blishen, op. cit.

9. Provincial Inventory of Nurses, op. cit., Table 11.

10. Canadian Nurses Association, op. cit., p. 59.

11. Chapin, op. cit.

12. Canadian Nurses Association, op. cit., p. 56.

13. Campion, F.L. A Report on the Project for the Evaluation of the Quality of Nursing Service. Ottawa. Canadian Nurses Association. 1966.

14. Ibid.

15. Ibid.

16. Kropp and Verner, op. cit.

17. Siegel, S. Nonparametric Statistics for the Behavioral Sciences. Philadelphia. Saunders. 1965. p. 23.

18. All other comparisons have been omitted.

19. Siegel, op. cit., p. 23.

CHAPTER III

THE INSTITUTE AND ITS EVALUATION

This study was an investigation of the changes in behavior perceived by a sample of participants at the institutes. Because the interviewees were asked for subjective evaluations of changes in their behavior as the result of a specific educational experience, the stated objectives of the institute were not pertinent to the study. An observational analysis of the institute was made with respect to new knowledge and its presentation, provision for modification of attitudes, and specific recommendations for practice, which were pertinent.

The Learning Situation

Relevant to the purpose of this study is an exploration of behavioral learning theory concerning what learning is and under what circumstances it occurs. Learning is defined in the behavioral sciences as a change in behavior which is more or less permanent.[1] For change to occur there must be a felt need for change, a climate conducive to change, an opportunity to practice the new behavior, and later reinforcement if it is to remain a part of the individual's repertoire of behavior patterns.[2] There is an extensive and growing literature on the behavioral measurement of learning and learning situations which has been studied by the author. The learning situation

and the factors which influence it are described in Appendix E.

It is obvious that the opportunity to practice changed behavior and later reinforcement cannot be provided in an institute. In designing an institute, however, both the other factors and information pertinent to changing practice should be considered.

Knowledge. The institute was observed for the content offered and the methods used in the presentation of the material. The subject content of the institutes included the value and purposes of evaluating staff members, techniques and methods of evaluation, evaluation forms, ambiguous terminology, the differences between administration and supervision, personal feelings and biases, direct and indirect counselling, and employee expectations. Each topic was introduced by the speaker and followed by small group discussion and/or discussions from the floor. The speaker summarized the main points which emerged from discussion. When small group discussions were used, a group recorder reported the discussions and attempted to answer questions from the floor.

The learning experiences were provided through various methods of presentation, which included lectures, discussions, various audio-visual media, and participation in problem solving. A film, "The Eye of the Beholder," was shown, depicting eloquently the individual cognitive worlds of each of the actors. Two institute participants presented a role playing sequence, with one playing the head nurse and the other an aggressive staff nurse. One of the problems presented was

a written case study which gave too little information for solution of the problem. Another centered on the terminology for evaluating staff; groups were asked to designate the terms they would use to describe various levels of performance for the same employee group and then to define the terms.

The subject content and methods of presentation were related to the past and present work experience of the participants. The relevance of both were increasingly evident as the participants became involved in group discussions. Different approaches and different situations will often release stored information into the meaningful or useable realm of learners. (Appendix E) This meant that a new relatedness with existing knowledge occurred for the institute participants. The observer was satisfied that the content and its presentation were such as to facilitate the learning for which the institute was designed.

Attitudes. Those planning an institute or similar educational experience anticipate that new knowledge will subsequently be used by the participants. A study of the literature reveals that the effectiveness of any educational experience may be influenced by the attitudes with which the participants arrive. (Appendix E) The educational experience should, therefore, be designed so that attitudes may be modified during the course of the program.

As attitudes can be influenced by the credibility of the communicator in the perception of the learner, by the form and manner of the presentation of the material and by the circumstances of delivery

(Appendix E), as well as by the involvement of the individual with the material, these factors must be considered. Observation was made of the types of presentation and the types of questions posed for small group discussions at the institute.

The discussion periods serve several purposes in such a setting: 1) to bring material into the practical or meaningful realm of the discussants, and 2) to reduce the apathy of the discussants through involvement as group members. All groups have a therapeutic as well as an educative value even when they are not specifically so designed. (Appendix E) The behavior of the participants was observed during the small group discussions. There was nothing specific planned at this institute to use the coffee or lunch breaks for furthering discussion, but the observer also listened to the participants at these times.

The observer was satisfied modification of attitudes was provided for in the design of the institute.

Practice. There was no provision made at the institute for a change of practice, but its explicit purpose was the imparting of knowledge by which practices could be modified. The effect on practice had, therefore, to be determined later when there had been an opportunity for the participants to apply some of their knowledge and attitudes in the practical situation. An appropriate interval was therefore allowed to elapse between the conclusion of the institute and the collection of data.

Evaluation of Supervisory Training Programs

Evaluation research is described by Sutton as the extent to which the objectives of a given program are achieved by the participants.[3] Klineberg states that evaluation should be restricted to methods which yield evidence that is "objective, systematic, and comprehensive."[4] As adult education is heterogeneous in interests, methods, programs and techniques, and as adult educators have such widely divergent concepts of the objectives of their educational programs, evaluation research projects have been scarce, divergent and not usually comparable.

Management and supervisory training programs in business and industry have increased rapidly in the past twenty years. The theoretical aspect of evaluating or measuring the effectiveness of these programs was of interest to the social researcher, who stated that any change was an indication of success and/or progress. For purely practical reasons, the program directors were interested in the quality of their offerings, and the administrators of the employing agencies were interested temporally and financially in whether increased production or performance resulted. Attempts to evaluate the results of these programs have been numerous, but the outcomes have been frustrating and not always fruitful. According to McLemore, the literature on the research of the effectiveness of these programs is most valuable in providing information about the difficulties the researcher will encounter.[5]

To determine the success of a training program, Mahler states that is is necessary to know the objectives of the program, to be able

to identify and measure relevant outcomes, and to demonstrate a relationship between observed changes and the training experience.[6] However Corb warns that the relationship of improved performance to easily measured results is complex.[7]

The major problem areas then in the evaluation of a program are those of the criteria to be measured, and of the actual inference between changes and experience. McLemore stated "It should be clear . . . that the connecting chain from program objective to training outcome is not at all simple, and that numerous problems are to be encountered at every point along the way."[8] Corb adds that the development of suitable criteria becomes more difficult "the further removed the training is from manual or manipulative skills, and the closer it approaches the functions of cognition, judgment, and personal effectiveness."[9]

Thus, even if the programs do achieve their objective of improved job performance of the participants, it is seemingly impossible to prove it. Evaluative techniques have not yet been developed to provide objective proof of the effectiveness of supervisory training programs. The present study was not designed to establish or examine objective "proofs" such as may be used by an employer or external evaluator, but to examine the reactions of the participants (employees) and their relationship to the training program and to certain aspects of the educational and experiential backgrounds of the participants.

The Construction of the Interview Schedule

The initial step in the present study was to decide how to elicit the information needed to discover whether or not the institute participants perceived any change in their behavior in evaluating staff because they had attended the institute. Although the objectives of the institute were known before the event, the experience and practices of the participants were not. The questions devised at this stage were all deemed unsatisfactory. The necessary questions could not be determined on the basis of the observed analysis as each head nurse had a different experiential and procedural background. It was decided that unstructured interviews would be used for four or five participants not involved in the study sample. From these interviews possible areas for questioning would be designated. After twelve interviews it was further decided that an unstructured interview would be used for the study sample. Information was to be gathered in the general areas of agency policies regarding evaluations; individual practice before the institute; anything new in subsequent procedures; any change since the institute in orientation, supervision, teaching, anecdotal notes, evaluation, and interviews; and resources from reading or persons most helpful with these changes.

The Pilot Study

During the latter part of June, almost three months after the institutes, the author interviewed twelve registered nurses who had attended the institutes. These participants were not among those

selected for the study. The inverviews were used to elicit answers to both the background and change sections of the interview schedule.

It was difficult in each interview to determine whether each interviewee had actually changed or whether there was an unconscious need to express change. There was also the problem of determining the evaluative behavior of the individual before the institute as compared with after.

It was decided at this time that the interviews would, wherever possible, be conducted at the place of employment, as there seemed to be a considerable difference in response to the environment. The interviews took between one-half and three-quarters of an hour each. They were, on the whole, apparently relaxed and non-threatening to the interviewees once rapport had been established.

The Study

During July and early August, the nurses in the sample and alternate lists were interviewed. Arrangements were made through the Directors of Nursing of the employing agencies for interviews at times which seemed to be convenient for the interviewees. In all cases, an office was provided. The cooperation received by the author from the employing agencies and the interviewees was exceptionally good.[10]

Background data was readily obtainable from the respondents. The institute and resulting changes were willingly discussed, but varied tremendously from interview to interview as the respondent varied from loquacious to reticent. For some, the institute was a form of

reinforcement or reassurance of what they were already doing. For others, it was relatively new material. In each case the interviewee's previous procedures and attitudes toward evaluating personnel had to be determined so that degrees of learning could be ascertained. Judgment or evaluation of the level of competence of the interviewee on her evaluative skills was not pertinent. The pertinent factor was whether she perceived any change in what she was now doing as a result of having attended the institute.

Compilation of Results

The pertinent questions at the interviews were concerned with how the respondents had supervised, evaluated and interviewed their staff members, and whether they perceived any change in these procedures or methods since the institute. They were also questioned about new staff members, reorientation, adjustment to the unit, teaching, evaluating, and discussion of problem areas. Each respondent was questioned about her philosophy of evaluation as an ongoing process, and her reasons for evaluating staff members.

From the notes made at the interviews, the patterns of evaluation in each agency were extracted, (p. 83) and the other information was interpolated into a structured format. (Appendix C) This format was designed from the interview notes. As will be obvious, some items were rarely mentioned. It was decided that all categories would be retained, however, for better coverage of the material. The tabulations were made regarding a perception of no

change or change, and, with the latter, whether the change was in knowledge, attitude, practice or their subcategories. The seven subcategories of knowledge, the seven of attitude, and the six of practice (with their further divisions), were not used finally for comparison purposes, as few significant differences were apparent even between the larger categories. The sample was too small for such fine divisions.

The results from the tabulations are given in the next chapter, as well as significant comparisons of the changes in relation to the background data which was presented in Chapter II.

Footnote References

1. Clayton, T.E. Teaching and Learning. Englewood Cliffs, N.J. Prentice Hall. 1965. p. 45.

2. Melton, A.W. Categories of Human Learning. New York. Academic. 1964. p. 316.

3. Sutton, E.W. Analysis of Research on Selected Aspects of Evaluation in Adult Education. Doctoral Dissertation. Ann Arbor. Florida State University. University Microfilms. 1966.

4. Klineberg, O. The Problem of Evaluation. International Social Science Bulletin. 1955. 7:346-352.

5. McLemore, S.D. and R.J. Hill. Role change and Socialization in Nursing. Pacific Sociological Review. Spring, 1965. 8:21-27.

6. Mahler, W.R. Evaluation of Management Development Programs. Personnel. September, 1953. 30:116-118.

7. Corb, J.D. How to Measure the Results of Supervisory Training. Personnel. March, 1956. 32:378-379.

8. McLemore, S.D. and R.J. Hill. Management-training Effectiveness - A Study of Nurse Managers. Austin, Texas. Univ. of Texas. 1965. Chapter 4.

9. Corb, op. cit.

10. The author was continually surprised at the interest expressed in the outcome of this study, not only on the part of those interviewed, but by their supervisors and directors of nursing who arranged the interviews, by other nursing personnel, by non-nursing administrators, by the sponsoring agencies, and by those involved in educational ventures of all kinds.

CHAPTER IV

RESULTS OF THE STUDY

Perception of Change

Of the 45 respondents in the sample, 41 or 91% expressed a perception of change in their behavior following the institute. Those who expressed no perception of change did nevertheless state that the institute had been a reaffirmation of what they were already doing in evaluating staff members. Three of these four respondents were supervisors in public health agencies and the fourth was a head nurse in a medium sized hospital.

Where a change in behavior was perceived, it occurred with respect to knowledge, attitude, or practice, or some combination of these. Seventy-six percent of the total respondents perceived a change in knowledge, 62% in attitude, and 76% in practice. (Figure 22) Forty-nine percent of the respondents perceived a change in all three areas, 11% in knowledge and attitude, 11% in knowledge and practice, 2% in attitude and practice, 5% in knowledge only, and 13% in practice only. There were no respondents who perceived a change in attitude only. (Figure 23)

Knowledge. Seventy-six percent of the respondents perceived a change in behavior in knowledge. The subcategories of knowledge change

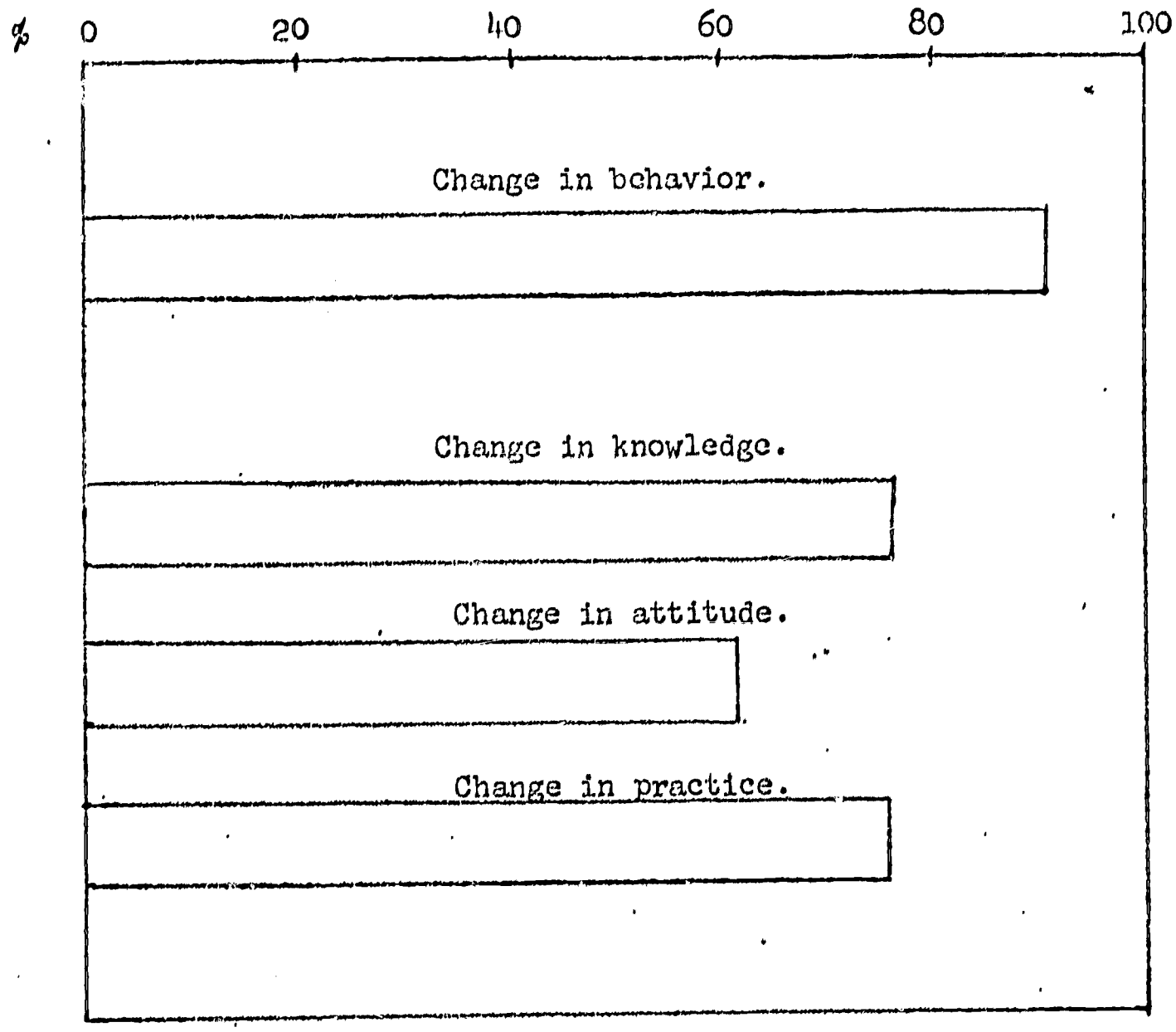

Fig. 22. Change in behavior and change in knowledge, attitude and practice.

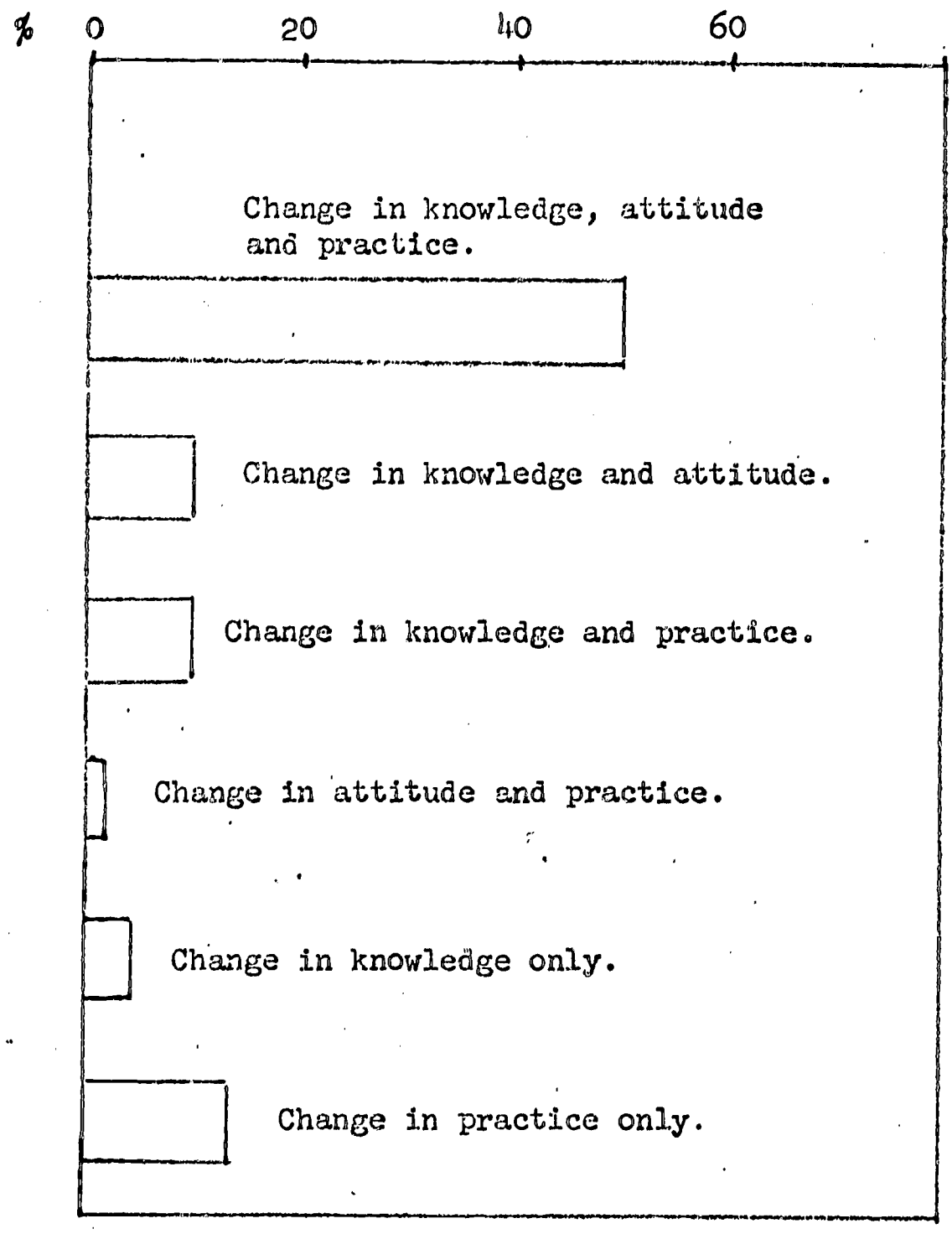

Fig. 23. Distribution of types of changes within overall change of behavior.

indicated by the respondents were:

47% - Better understanding of the reasons for evaluation.

29% - Better understanding of discussing evaluations.

27% - An awareness that others in similar positions have similar problems.

22% - Better understanding of recording or writing evaluations.

13% - Recall and reaffirmation of previous knowledge.

9% - Better understanding of preparation of evaluations.

9% - An awareness that there are other points of view besides one's own.

156% - Total

As can be seen, the percentages in the above list total 156%. This was because many of the respondents indicated more than one sub-category of change in knowledge. Two percent chose five categories, 9% chose four, 17% chose three, 9% chose two and 39% chose only one. There was no perception of change in knowledge by 24% of the respondents.

Attitude. Sixty-two percent of the respondents perceived a change of behavior in attitude. This category was further subdivided. The sub-categories of attitude change indicated by the respondents were:

40% - Different philosophy about evaluations.

38% - More confidence in doing evaluations now.

24% - Evaluations are easier to do now.

18% - An awareness that there are other points of view besides one's own.

9% - More confidence in ability to fill head nurse position now.

7% - Expectations are now two-way.

4% - Different feeling about interviews.

140% - Total

As the percentages in this list total 140%, it can again be seen that more than one category was chosen by some respondents. Four percent chose four subcategories, 24% chose three, 18% chose two, and 16% chose one. There was no perception change in attitude by 38% of the respondents.

Practice. Seventy-six percent of the respondents perceived a change of behavior in practice. The subcategories of practice change indicated by the respondents were:

44% - Interview practice.

29% - Supervisory practice.

29% - Preparing, writing, evaluation reports.

24% - Anecdotal notes.

20% - Orientation practice.

2% - Teaching practice.

148% - Total

As the percentages in this list total 148%, it can again be seen that some respondents chose more than one subcategory. Seven percent chose four, 22% chose three, 13% chose two, and 33% chose one. There was no perception of change in practice by 24% of the respondents.

A Comparison of Perceived Changes and Background Data

The level of significance and its calculation in this section were obtained similarly to that described in Chapter II. A .05 probability was the level of significance chosen.

Although 290 comparisons were made between the perceived changes and the background data, only eight of the comparisons showed significant differences. In summary, change of behavior was perceived differentially by those with different basic academic education and by those with different post basic nursing education. Knowledge changes were perceived differentially by those in different age categories, by those with different amounts of nursing experience, and by those employed in different sized agencies. Attitude changes were perceived differentially by those with different post basic nursing education and by those with different amounts of nursing experience. Practice changes were perceived differentially by those in different sized hospitals.

Five of the background categories correlated significantly with change, i.e., those of age, basic academic education, post basic nursing education, years of nursing experience, and size of employing agency. Of these five, post basic nursing education, years of nursing experience, and size of agency were significantly different with respect to two areas of change. None were significantly different consistently.

Overall Change of Behavior. In the comparison of the overall change of behavior with background data, only two comparisons were significantly different. (Figure 24) The comparison of those with no

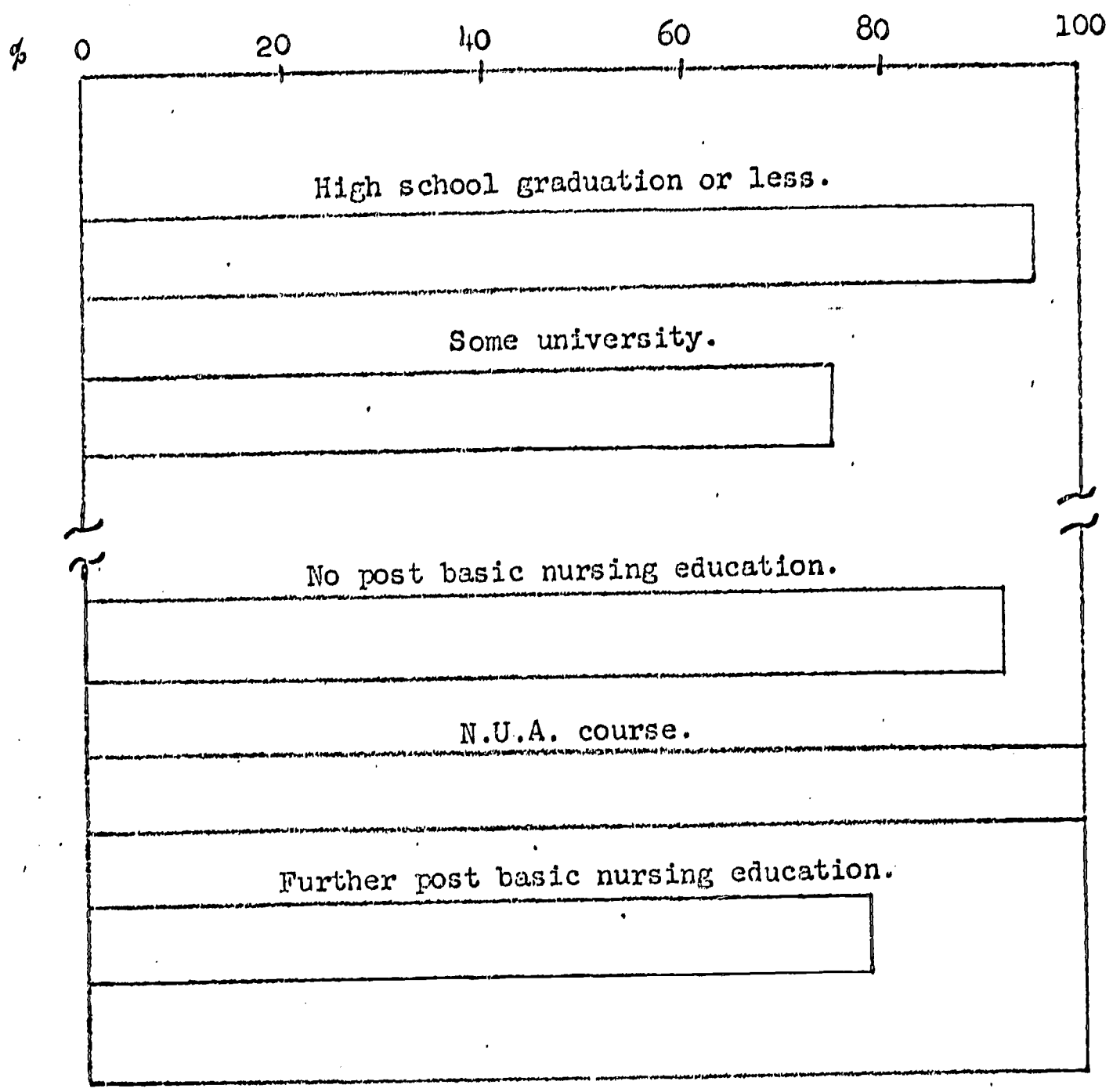

Fig. 24. Change of behavior related to significant background categories: basic academic education and post basic nursing education.

post basic nursing education, those who had completed (or were completing) the N.U.A. course, and those with further nursing education, revealed that 91%, 100% and 79% respectively perceived an overall change of behavior; and comparison of those with high school graduation or less and those with more, revealed that 97% and 77% respectively perceived an overall change of behavior. Most change in the first grouping was perceived by those with the N.U.A. course. Twelve of the 17 respondents in this group were students during 1967 or 1968, which was unforeseen before this study was done, and no basis for differentiation was established. These respondents were delighted with the reinforcement of their course by the institute, but were not able, of course, to distinguish which influenced their changed behavior the most or in which areas. Those with no post basic nursing education perceived a greater change with respect to knowledge and attitude than the other two groups. This could be due to the greater amount of new information or the different points of view to which they were exposed as compared with the other groups. Those completing the N.U.A. course perceived a greater change in overall behavior, possibly as they were having more recently acquired information reinforced.

The fewest changes were perceived in all areas by those who had completed further nursing education. This was interesting in view of the fact that the data on this group reveals that more than half had high school graduation or less, were single, were over 45 years of age, and had graduated in schools of nursing outside British Columbia.

Three-quarters of the group had more than 15 years of experience, two-thirds had been head nurses more than five years, and three-quarters worked in small agencies. This group ranked low (at 11) on the Chapin Social Participation Scale.

Knowledge Change. The present study indicates a perception of change in knowledge for 76% of the respondents. Of these, 79% also perceived a change in attitude, and 79% also perceived a change in practice.

Fewer of the older than of the younger respondents perceived a change in knowledge (61% and 91% respectively). Those with less and more nursing experience perceived a significant difference in knowledge change (93% and 67% respectively). (Figure 25) As those under 45 years of age were generally those with less nursing experience, these differential perceptions could be expected. Whether the difference was due to learning what was necessary on the job, or whether those who were older and more experienced were less willing to change was not determinable. The older respondents might have perceived less change as they were already using much of the material presented at the institute. They also had, on the whole, more basic academic education, more experience in nursing and more experience in head nurse positions. They might also have formed cognitive configurations which were not amenable to changes, and therefore they could not see the relevance of the new material to their personal performance.

A comparison of those in smaller and larger agencies revealed

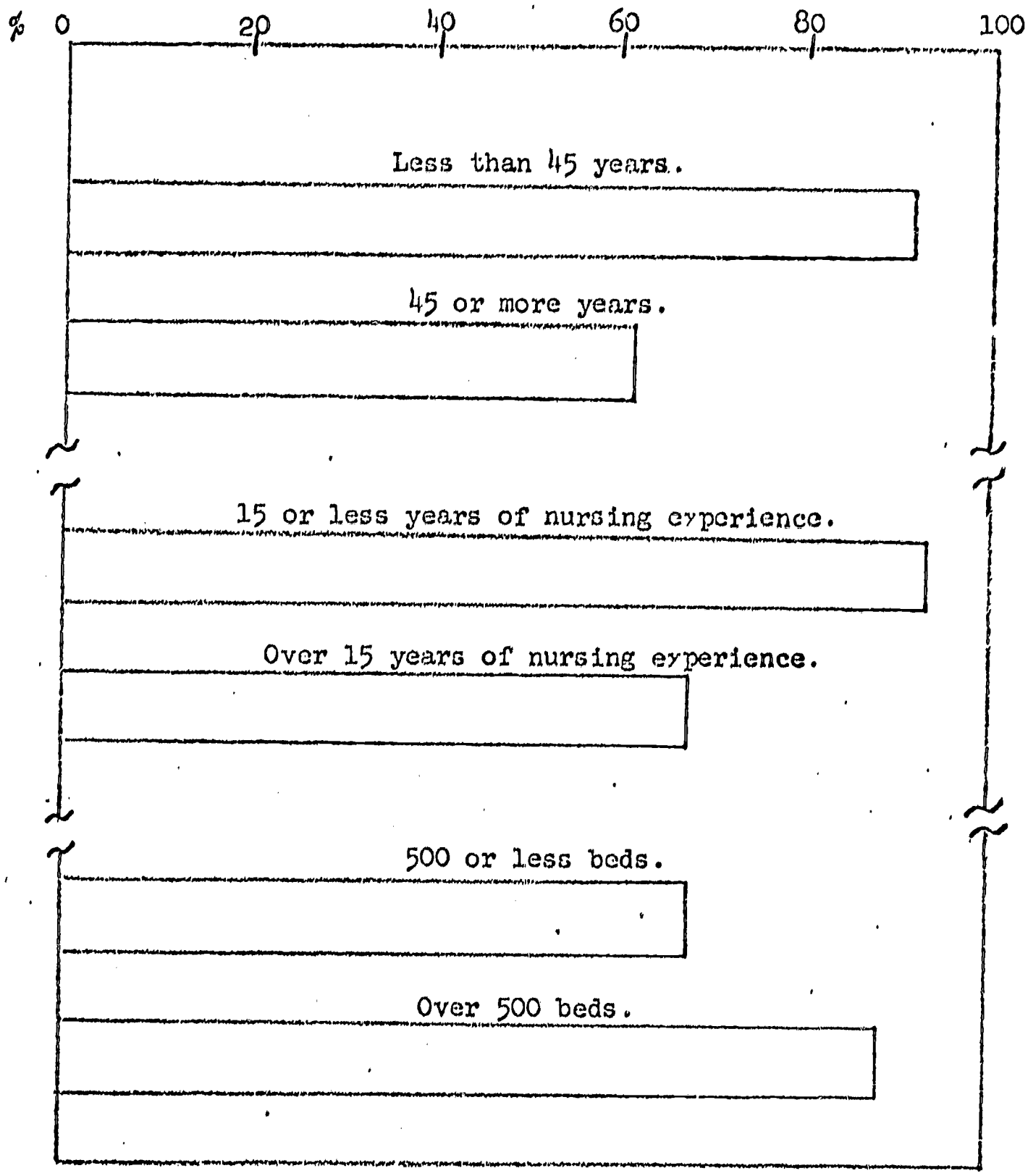

Fig. 25. Change in knowledge related to significant background categories: age, nursing experience and size of employing agency.

that 67% and 89% respectively perceived a change with respect to knowledge. This could be due to the difference in the communication patterns in the different sized institutions. The communication channels tend to be more open and easier to use in smaller units, and more closed and therefore more difficult in larger units. Communication is often more difficult in a nursing unit of a large hospital than in a small hospital. The differences in communication patterns are the result of differences in the visibility of communicants, in the number of communicants involved, and in the number of contacts with each other. The smaller the group, the easier the communication pattern usually is.

Attitude Change. The present study indicated that 68% of the respondents perceived a change in attitude. Of these, 96% also perceived a change in knowledge and 82% in practice.

Significant differences in attitude change were perceived by those with less than 15 years of nursing experience and by those with more (80% and 53% respectively). Differential perceptions were also indicated by 82%, 50% and 50% respectively of those with no post basic nursing education, those with the N.U.A. course, and those with further nursing education. (Figure 26) Obviously from these figures, the respondents with less experience and less post basic nursing education were less aware of the philosophy and reasoning behind some of the material presented at the institute. Those with more experience and more education were less aware of those feelings which the former group found were changed.

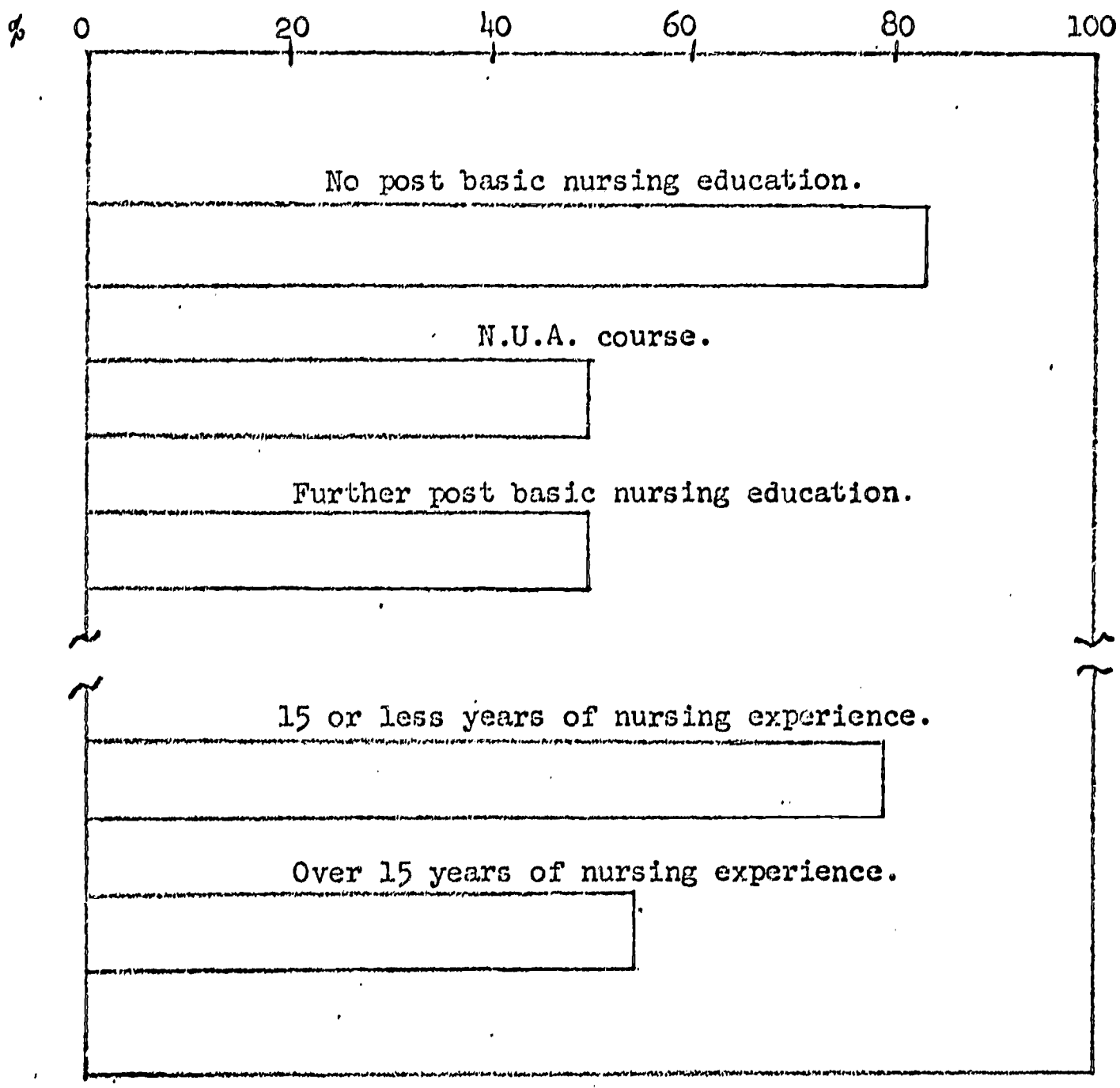

Fig. 26. Change in attitude related to significant background categories: post basic nursing education and nursing experience.

Practice Change. In the present study, 78% of the respondents indicated a change in practice, although the halo effect may have pertained. Of these, 79% also perceived a change in knowledge, and 68% in attitude.

A differential perception of change in practice was indicated by those in smaller or larger agencies (67% and 89% respectively). (Figure 27) Whether or not this change was due to the communication patterns mentioned earlier, was again difficult to assess. It was anticipated that the better qualified nurses would be employed in the larger institutions, but this certainly was not the case with the study sample. The anonymity and difficult communication patterns in the larger institution might make it more possible for a head nurse to be unaware of what her compatriots are doing. This would be less likely to occur in a smaller institution.

Summary

Following the institute, 91% of the respondents in the sample perceived a change of behavior and 9% did not. Of all respondents, 76% perceived a change in knowledge, 62% in attitude, and 76% in practice. Almost half the respondents perceived a change of behavior in all three areas. Comparisons of change with background categories showed significant correlations with regard to age, basic academic education, post basic nursing education, years of nursing experience, and size of employing agency. None were significantly different consistently.

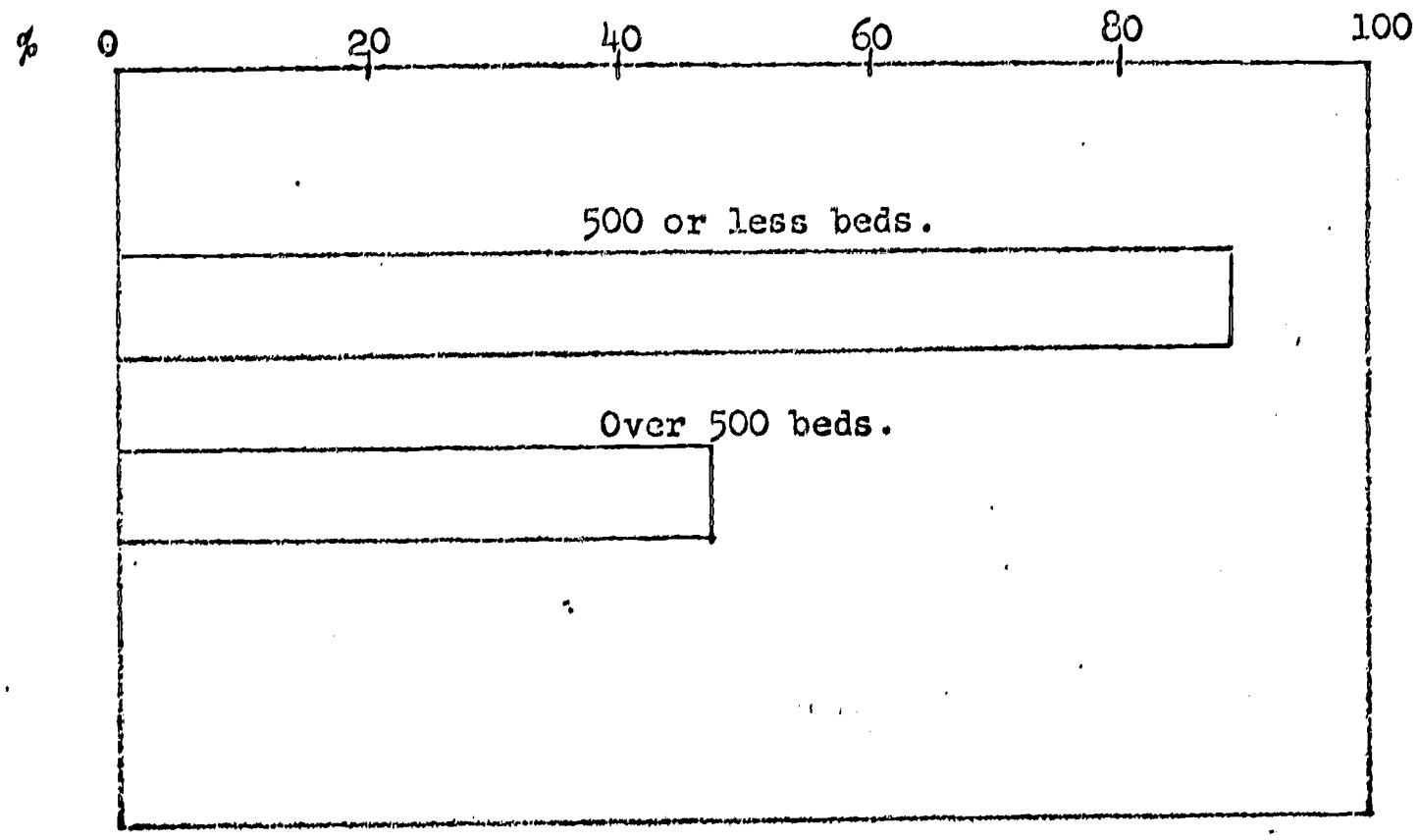

Fig. 27. Change in practice related to significant background categories: size of employing agency.

CHAPTER V

DISCUSSION AND IMPLICATIONS

The participants in this study were described in Chapter II, the methodology used in Chapter III, and the results of the study and comparisons of change with background in Chapter IV. It was felt that an itemized summary, chapter by chapter would be meaningless and wasteful of the reader's time. This chapter is, therefore, devoted to discussion of the study as a whole, including some aspects of the interviews and work context which were not subjected to statistical treatment; to an assessment of the methodology and its resultant conclusions; and to the several types of implications arising therefrom, some of which are interpolated in the text.

The Interviews

The interview itself posed a premonitory threat to some of the nurses, as they appeared to feel that its purpose was to examine how much they had learned at the institute, or how efficient they were in evaluating their staffs. In each appointment for an interview, it was stressed that nothing needed to be prepared for the interview. Nevertheless, some had carefully reviewed their notes, others had brought their notes before or after having reread them, while still others apologized for not having had time to read them. Some were able to quote almost verbatim from these notes, and were disappointed,

but also relieved, that they were not to be examined.

It was apparently a relief to many that their participation in the study would remain anonymous. Quite a number were interested in discussing specific problems they had encountered, and tried to turn the interview into a tutorial. Personal and family problems, supervisor and subordinate problems were all included. Obviously there was a degree of apprehension or fear involved in the anticipation of the interviews on the part of some of the interviewees. When this was relieved, there was an anxiety to discuss problems which may have been the cause of the underlying feelings of insecurity.

Most were very interested in what the interviewer hoped to discover, and in educational ventures in general. Many, especially in the younger age groups, were hoping to take further formal education, and some were starting formal courses in the near future. The institute apparently served as an impetus to some and an encouragement to others.

Expressed Views of the Institute

The institute was enjoyed and accepted by the participants as indicated by both end-of-meeting questionnaires presented by the sponsors at the time of the institutes, and by the Kropp Verner Attitude Scale presented to the respondents during the interviews. The median choice on the latter scale was high on the positive or acceptance side.

Some of the respondents expressed the opinion that similar institutes should be held every few years so they might be kept up-to-date in practice, even though the material might not be new.

They felt the reassurance and reaffirmation of their current practices were very encouraging, and gave them more confidence to try new practices and to encourage their subordinates to change.

Comments heard at the institute verified the credibility of the speaker in the opinion of the participants, and the practicality of the material they were being given. Criticisms were concerned with the physical environment regarding noise, heat and acoustics.

Reading

Previous to the institute, a short bibliography was sent to each registrant. On the end-of-session questionnaires used by the sponsors, those attending indicated that they had read at least one reference.

At the institute, a book exhibit and book list pertaining to the institute topics attracted considerable attention from those attending. Order forms were completed by some for personal copies of the exhibited and listed books. It was not possible to obtain details of the orders.

At the interviews, the respondents were questioned about their reading. On the whole, most of them did not read very much. Few felt they had read more because they had attended the institute. Those who did, did not feel they had gained appreciably. The majority of those who expressed an increase in their reading attributed the cause to the N.U.A. correspondence course for which reading was required.

Many appeared to continue reading after completion of the course. The main source of information appeared to be the Canadian Nurse, the official organ of the Canadian Nurses Association which all registered nurses receive as part of their registration. Many of the nursing journals mentioned to the respondents were unknown to them. Obviously, this institute did not change the reading habits of the participants.

The Work Situation and its Effect upon Change

The situations in which the respondents function varied markedly from agency to agency, and from department to department, even within the same agency. From the information gathered at the time of the interviews, the policies of the seventeen agencies represented by the respondents were extracted and analyzed.

Of the seventeen agencies represented by the respondents in this study, nine required regular reports on staff members, usually after the first three or six months, then annually or biannually, and at the termination of employment. Four agencies required a report at the end of the initial probationary period, but did not enforce reports thereafter. Three agencies had forms available but did not enforce any regular policy of evaluation. The seventeenth agency did not have any policy of evaluating or interviewing staff members at the time of the institute.

Within several of the larger hospitals, the pattern of evaluation was inconsistent, apparently dependent upon the departmental supervisor rather than upon the administrative policy of the

department of nursing. The majority of head nurses prepared regular evaluation reports in these hospitals with the support and encouragement of their supervisors. The evaluations were also variously done by the head nurse and her supervisor, by the supervisor with incident reports prepared by the head nurse, or by the supervisor without reference to the head nurse.

Programs for regular interviews with staff members varied as greatly. The interviews were usually conducted by the person preparing the report (head nurse or supervisor), although they were also conducted by the supervisor with a report prepared by the head nurse, or following an interview of the staff member by the head nurse. In several instances head nurses stated that reports were regularly changed by the supervisor after the head nurse had interviewed the staff member, but before the report was sent on to the personnel files. In three instances, respondents stated that reports had disappeared after disagreement between the supervisor and head nurse about the assessment of the staff member.

Reports were usually seen and signed by the ratee, although occasionally a report on poor performance or a specific incident was filed in the personnel file without the ratee being aware of its existence. This practice was reported in hospitals of varying sizes.

The majority of the respondents had control over staff evaluations and interviews with the support of their supervisors. In other cases, the head nurses had accepted their situations without protest, pleased that their supervisor relieved them of the onerous

task. Another group of head nurses resolved their dilemma by holding regular "discussions" with their staff members. Most of the respondents expressed their gratification and appreciation of the tremendous help they received from their supervisors through guidance, support and encouragement to carry out their head nurse functions. As one of the latter group expressed it, "I can hardly wait for her to get back from her vacation." She had collected pages of data to follow through on some staff education ideas she and her supervisor had previously discussed.

During the course of conducting the interviews for this study, seven supervisors of respondents came to meet the interviewer, either to discuss the results of the institute, or to ask for reading or consultant references for specific areas of evaluation or supervision of staff.

Only four of the head nurses specifically mentioned having received evaluation reports at any time themselves, although quite a number stated that they would appreciate being evaluated by their supervisors.

At the time of the interviews, new evaluation forms had been designed in two agencies by the head nurses in a committee of the whole, new forms were being planned in two agencies, and a format was under consideration for the agency with no previous form. In other agencies, the head nurses had had many informal discussions on the format they used for evaluations, its uses and its interpretation.

In two agencies, verbal interviews at the termination of employment were being replaced by regular reports and interviews instigated by the head nurses. Specific plans for libraries were underway in three agencies, started in one since the institute, and given an impetus by the institute in the other two.

In summary, sixteen of the seventeen agencies represented by the respondents in this study had some system of rating or evaluating employees. There was little standardization within or between hospitals in the methods or scheduling of evaluation. In seven of the agencies a stimulus or impetus toward change was reported to have occurred because of the institute.

Four of the respondents expressed a feeling of unworthiness or inadequacy in their head nurse positions. They seemed to feel that they had been an integral part of their staffs and resented being regarded as superior in any way. These same head nurses had difficulty with staff reports as they felt evaluation was an infringement on personal privacy. If performance is considered one's own business, and not the business of the person responsible for the nursing care of the patients on the unit, the head nurse role is obviously neither appreciated nor understood.

Obviously these head nurses did not benefit from the institute, even though they perceived changes in their behavior. They needed a different type of educational experience, perhaps therapeutic in nature, or possibly they should be reverted to bedside nursing.

Some of the head nurses expressed surprise that their subordinates would like instruction in unfamiliar procedures and routines in the nursing unit. They expressed the view that teaching of subordinates meant belittling their competence, as they were graduate nurses. These head nurses also felt that personal acceptance by their staffs would diminish if they indicated a need for the subordinate to learn something new. This viewpoint is contradictory to the rationale of evaluation as an ongoing process for personal and professional growth and to the concept of continuing education. Possibly planned head nurse discussions on teaching within the agencies could alter this viewpoint.

Of the respondents who expressed no perception of change as a result of attending the institute, three were not employed in hospital settings. Of the respondents who perceived change, most felt they could instigate some changes regardless of their work situation, although others felt that nothing very much could be done. Some settings impede changes that need to be made, while others facilitate them. Whether the opinions expressed by the respondents reflect a quality of these respondents, or of the work situations, was not revealed by this study.

The Effect of the Institute on the Participants.

Ninety-one percent of the institute participants perceived change as the result of attending the institute. These were the specific tabulated changes in this study, but other explicit and implicit changes also occurred. These latter changes included the adoption of innovations, the acceptance of different cognitive worlds, the acceptance of different expectations, and remotivation.

As the respondents indicated perception of a considerable amount of change, they must have felt a need to change. Whether these feelings were present before the institute, were engendered through the institute process, or were indications of a willingness to please at the time of the interview, is a matter of speculation. Whichever was behind the indicated changes however, the institute seemed to help some of the respondents feel more adequate in their positions through a reinforcement of current performance, or through changes which gave them more security in their performance. The responses indicated that th engendered changes were congruent with the behavior which they felt they needed.

Those who perceived no change as a result of attending the institute were, generally, those with more post basic nursing education, more nursing experience, and more head nurse experience, and who were not employed in hospital settings. These factors indicate that change might not occur because performance already conformed to recommended practice, or because there seemed no personal advantage to change.

The greatest perception of change was seemingly perceived by younger head nurses, those in larger agencies, and those who had less basic academic education, less post basic nursing education or less nursing experience. Further research would be needed to validate this, however. A significantly greater change in overall behavior and in attitude was perceived by those with less post basic nursing education than by those with more; in knowledge and attitude by those with less nursing experience than by those with more; in knowledge and practice by those employed in larger agencies than by those in smaller ones; and in

overall behavior by those with less basic academic education than by those with more, and by those who were younger than by those who were older.

Interestingly, the relationships expected when the study started were that greater change would occur for the younger, less educated, and less experienced head nurse, especially in the smaller agencies. As the results show, these expectations were only partially realized. The most surprising result was the expression of greater change by those in the larger agencies. Also, those with less head nurse experience did not perceive as significant a change in behavior as those with less nursing experience. Otherwise, the results followed the expected pattern and substantiated the results of other studies.

The trends in change which became apparent in the study were in three general areas, each of which included many of the subcategories used in the tabulations. These general areas were those of adoption of innovation, different cognitive worlds, and different expectations.

Adoption of Innovations. Some of the respondents reported that the institute had given them a better understanding of information they already had, but which they had not previously used. The adoption of new ideas is seldom spontaneous, as the adopter has to try them out, understand their use, assimilate them into previous cognitive patterns, see them as desirable to him personally, and see them as meaningful in his social context. In the group process of the work situation, the adopter has to feel he will receive the approval of his subordinates and

superiors for his new style of behavior before he is willing to change his behavior patterns fully. Many of the respondents described the increased cooperation and interaction of their staff members in response to their changed behavior. This response would probably increase the possibility of the new behavior being adopted permanently.

Different Cognitive Worlds. The number of respondents who expressed surprise that other people had different points of view from their own was rather disconcerting. The differences between patients are continually stressed in nursing, although seemingly this knowledge did not transfer to differences between subordinates. This aspect was mentioned in different ways by a quarter of the respondents during interviews. Both the film and the case study at the institute were commented on by respondents in the context of efforts to understand subordinates through allowing them to express their feelings about situations. Evidently these respondents had previously presented one point of view - their own - and expected cooperation from the subordinate.

Different Expectations. Some of the respondents were disconcerted to discover that not only did they have expectations of their staff members, but that staff members had expectations of them. This was expressed quite vociferously in discussions at the institute, but seldom mentioned in individual interviews. Some respondents had found that their changed behavior regarding supervision, evaluation and interview-discussions was accepted readily by staff members, that discussions were two-way more than formerly, and that they were more comfortable in discussions as they felt more secure and adequate in their

own performance. More democratic attitudes appear to have been formed by these respondents.

If the head nurse has certain fixed expectations or cognitive sets before she interviews members of her staff as to exactly what she is going to say, plan, execute, do, etc., spontaneity and flexibility are lost. When a head nurse develops more democratic attitudes toward human relations, interviews may be unpredictable, but a better rapport for ongoing interaction usually develops. Apparently, the institute was effective in this respect, but it would not be possible to place a quantitative value on the results.

Performance Lags. For each person doing repetitive tasks, the maintenance of a satisfactory level of accomplishment tends to lag. Performance lags may be diminished, or at least arrested, through re-motivation of the individual. Evaluation of staff can accomplish this to some extent if the ratee grants credibility to the rater, and if the ratee feels he is improving. Workshops and insitutes, lectures and conferences occasionally serve this purpose also, as participants from different organizations discover how others of similar status feel about their problems and satisfactions, their various methods of problem solving, and their different points of view. Professional exchange of experiences may stimulate a person and make him feel more adequate to deal with a frustrating situation.

The most frequently expressed view of the institute was that the interviewee felt she had learned nothing new, but that it was reassuring to know she was going in the right direction. Even those who

indicated that they had perceived no change stated that the institute had reaffirmed what they were doing. The material had acted like 'a shot in the arm', as one respondent put it. This reaffirmation or reassurance bolstered confidence to carry on as the person gained a feeling of "togetherness" of both satisfactions and problems. The feeling of inadequacy to cope with problems often diminishes with the knowledge that others have shared and tackled similar situations in other agencies. Inasmuch as the institute specifically catered for group activities, it may be considered successful in providing reaffirmation.

There seemed to be little difference in the amount of change between the respondents in agencies with or without standardized policies for evaluations and interviews. The changes in overall policy in seven of the agencies represented in the study had occurred largely at the instigation of those who had attended the institute, although often all the head nurses were involved. However, changes in personal performance were likely to conform to group consensus.

As the turnover of head nurses in hospitals in Canada averages 16% annually, changes are inevitable. The difficulty of instigating and maintaining change in an agency not only involves changes in the practice of current staff, but adequate orientation of new staff. This all leads one to surmize that this would involve intrainstitutional continuing education, as well as interinstitutional continuing education and regular programs in both areas for remotivation.

Accomplishment of the Purposes of the Study

From the literature reviewed in Chapters I and III, it was

obvious that the present study did not meet the criteria necessary for effective research. The literature repeatedly emphasized that positive research results reveal the extent to which the objectives of a given program are achieved by the participants when measured by methods which are objective, systematic and comprehensive. This study did not try to assess objectively the way participants met the objectives of the program. The data was introspective and subjective; the method, though systematic, was partly impressionistic, and restricted. The relationship of improved performance to easily measured results discussed in the literature was said to be complex, and certainly in this study the relationship cannot be proved. The study showed improvement occurred, but it was measured in the perception of the respondent about her own performance, and is therefore limited by the introspective skill of the respondents and their professional integrity. When the performance to be measured is in the field of cognition, judgment and personal effectiveness, objective measures are not available. The subjective perception of the respondents could possibly have been measured against the judgments of their immediate supervisors, but these would also have been subjective evaluations. Possibly the only reliable results in terms of work situations were latent rather than manifest. Any value attached to the resultant conclusions therefore rests on two credibility factors inherent in the methodology, which is discussed in the next section.

Aspects of the Methodology

The purposes of the study were to evaluate the institute as an effective tool in continuing education, and to subject to critical analysis a method of evaluation. The first purpose could be considered to have been met if the results can be accepted on the subjective basis on which they were obtained, i.e., if the phrase "professional integrity" is accepted as a value, even though it is not statistically established.

In this study, the opinions of the respondents were accepted at a high level of credibility. Whether nursing is classed as a profession or as a technical training is still a controversial issue, but hospital practice is dependent upon the attitude of people toward their work and upon their acceptance of responsibility. The work of a nurse therefore cannot be compared to the work of a person in industry where production can be measured. In the examination of the effectiveness of continuing education on the work of a nurse, the writer sees no reason for not relying on the professional integrity of the respondents. In addition, high credibility was accepted, partly because the respondents as a whole expressed the opinion that they had learned nothing new at the institute, and partly because of the impressions received by the interviewer, to which further reference is made below.

The institute was designed to educate the participants, not to change institutions. If the perceived changes of the respondents were not reflected in institutional changes, this did not diminish the effectiveness of the institute. Apparently, however, institutional change was effected in seven of the institutions represented. Although

this was not an intention of the institute, it tends to support the credibility of the subjective responses.

If each respondent in this study had chosen each of the categories used in tabulating the results, 900 changes would have been indicated. The total number of changes perceived however, was 468, of which 169 were in knowledge, 146 in attitude, and 153 in practice. For those respondents who perceived change, this indicated approximately 12 changes for each. Statistics such as these are somewhat meaningless, except that they indicate a trend toward change.

When learning is defined as a change in behavior, the trend toward change can be considered as a definite and positive outcome of an educational experience. Perceived change was identified and attributed to the institute by the respondents. However, the study provided no evidence to show that the institute was de facto responsible for the changes which were perceived. The method used in the study did not allow for the discrimination of confounding variables. To provide such evidence would require an objective pretest to establish a baseline. Although pretesting was not possible for reasons mentioned previously, such a baseline could, however, only have been established for a subsequent change in knowledge. In view of the lack of uniformity of institutional practices as revealed in the study, such a test would be meaningless in terms of the behavioral concept of learning used in the study. The institute was designed to increase knowledge, but it was also designed to modify attitudes and to change practice through these factors.

There was a second credibility factor inherent in the method used, i.e., the interviewer. The acceptance of information supplied by

the respondents, which became the raw data of the study, as credible or otherwise was a judgment of the interviewer, who, using an unstructured interview technique, formed impressions while recording statements. In the design of the study this factor was held as a constant throughout: one research worker performed the observational analysis of the institute, all interviews, and all compilations and statistical treatments of the data.

A growing body of research leads the educator to believe that social and economic factors in life experience influence the learning processes of students. How far such factors influence the professional continuing education of nurses has not been established. How far, if at all, they applied to a continuing education program as short as a two day institute for head nurses was a second part of this study. If their influence was significant, the results would be of value in the planning of future institutes and in the selection of participants.

It was stated (Chapter II) that no specific profile of the participants in this study emerged. The 'typical' head nurse was not discernable from the data collected on the backgrounds of the respondents.

It was noted (Chapter IV) that the few significant results relating learning to the background categories involved those of age, education, experience, and size of employing agency, confirming what would appear to be common sense expectations. That these are the only factors, however, cannot be concluded from the present study.

As a research tool, the instrument used was inadequate to the

exploration undertaken. For example, of those 45 years of age or less, 5% of the sample indicated no change in behavior. This 5% actually represented only one person, while the other 95% represented 21 persons. A much larger sample, perhaps a total population, would be necessary to supply the numbers necessary for valid results, whether these proved negative or positive.

The examination of a total population to determine change after a two day institute would not be economically defensible, especially as it would probably prove impossible to distinguish change attributable to the institute from that attributable to recent continuing education in other forms, except at the level of knowledge. Factors other than the institute which might influence change would therefore have to be identified, isolated and measured. Apart from the expense of such research it is doubtful whether reliable discriminatory measures exist for the purpose.

Provincial statistics on nursing state that there were 653 registered nurses employed as head nurses in British Columbia in 1967. One of the larger hospitals, which employs approximately 8% of the provincial head nurse population, had an inservice educational program during 1967-8 on communication, which included both evaluating and interviewing personnel.[1] In March of 1968, over half the employed head nurses in British Columbia (other than the 8% mentioned) participated in the institutes on personnel evaluation held in Vancouver, Victoria, and Prince George. The study sample of 45 respondents was approximately 7% of the total population of provincial head nurses, or 14% of those

attending all the institutes. If these respondents are in any way representative of the head nurses in British Columbia (and the study revealed that they were), then the claim that changes could have occurred during the ensuing year is valid. The study, however, revealed that change in practice is subject to institutional policy. A claim that considerable changes have, in fact, occurred beyond the situations studied cannot therefore be validly made.

The limitations of the study were outlined in Chapter I and only confirmation of those factors brought out in the study is mentioned here. The results were possibly skewed by the inclusion of those in public health agencies, those in transient patient areas, those in supervisory positions above the level of head nurse, and those currently enrolled in the N.U.A. course. A better selection of a sample by educational and experiential background might have prevented this possibility. The study sample was a 25% random selection of a population of 189 registered nurses, and was too small for any statistically significant inferences to be drawn.

Conclusions

A number of conclusions were intrinsic to the study. Certain conclusions extrinsic to the study but inherent in the data are listed in paragraphs 5, 6, 7 and 14 below. While these conclusions are not relevant to the evaluation of the institute, they are relevant to the purposes for which it was organized, and therefore to continuing education

for nurses. Accordingly, they have been included here.

1. The institute was successful as determined by the enjoyment of the participants and by their perception of change in ways for which the institute was designed.

2. The institute was well designed as the level of positive results was high, and and as it provided the material which the participants needed to change their behavior in directions which they felt were congruent with their work situation.

3. Through influencing the participants, the institutes affected institutional policy in over 40% of the agencies represented. Although this was not an intention of the institute, it is practical evidence of its success as an instrument in continuing education.

4. The institute stimulated a greater awareness of the need for continuing education, professional help or consultant services, and for intrainstitutional education.

5. As the study showed a relationship of learning to education and experience, an institute should be based on a problem census and selection of participants should match institute objectives.

6. There is a need for recurring interval-of-time subjective evaluations such as this study, though not necessarily with more than arithmetic treatment of results. Through these, evaluation of past offerings would occur, and recommendations for other educational offerings would arise.

7. To reach significant conclusions of general application about the relationship of socioeconomic data to learning, there needs to be a much larger sample (perhaps a total population) than was used in this study.

8. The institute apparently served as an impetus to some participants and an encouragement to others toward further formal education.

9. The institute did not change the reading habits of the participants.

10. Many head nurses reported that their changed behavior led to increased cooperation and interaction with staff members, and that interviews were two-way more than they had been before the institute.

11. Some head nurses showed more democratic attitudes toward human relations, and indicated better rapport with staff members in interactions after the institute.

12. Group discussions were apparently helpful in providing reaffirmation of procedures for some respondents.

13. The methodology used was the objective study of subjective data; in this case, a statistical refinement of a process commonly used by professional administrators of continuing education programs. Although no statistical computation could be attempted, it was concluded that institutional policy changes recorded in the results supported the assumption of a high credibility of the data. It was also concluded that if no reliability is accorded professional statements by professional persons concerning their professional work (arguable as a basic assumption in the organization of much medical and educational activity) future studies using subjective data should start from and conclude at objectively determined points.

14. The study provided a number of recommendations useful in work situations and continuing education of nurses, as discussed in sections A and B of the Implications. It was concluded that these recommendations,

raised directly by the participants and exceeding the limits of data needed for computation, were a positive value of a methodology using unstructured interviews for the collection of subjective data.

Implications

The implications which arise from the study are in three areas: A) the work situation, B) further educational programs, and C) further research

A. The work situation.

1. The need of many of the respondents for reassurance and increased sources of information to answer questions became apparent during this study. Many expressed their desire for opportunities to discuss personally the various problems they encountered daily, and problems involved in supervising and evaluating a constantly changing staff. Possibly itinerant nursing consultants could help institute participants through individual tutorial instruction to recall forgotten material or to elucidate misunderstood principles given at an institute. This is rightfully the job of the supervisor, but she might also benefit from the services of such a consultant. The expense involved would be great, but the benefits might be well worthwhile, particularly if a large proportion of head nurses are without adequate preparation.

2. The need was also revealed for discussions within agencies on the evaluation process, with particular emphasis on those aspects

relevant to the needs of the specific head nurses and supervisors involved.

3. Many head nurses expressed the desire for personal evaluations by their supervisors. These should be part of an ongoing process.

4. There should be increased library resources available to nurses within their employing agencies.

5. There needs to be more emphasis within agencies on the concept of continuing education for all nurses.

6. There should be more emphasis on the need for teaching of subordinates and for encouraging their continued learning.

7. When head nurses express feelings of inadequacy or unworthiness disproportionate to their positions, they hould be given special - educational programs or possibly be reverted to bedside nursing. Their continued expressions of inadequacy would tend to undermine the confidence of their staffs.

8. All members of a work group should be included in the planning and implementing of changes for that group. Orientation of new staff members should include the implemented changes.

B. Further educational programs.

1. The lack of preparation of many of the head nurses in the sample (and of head nurses in British Columbia and Canada) indicated an increased need for institutes of the type discussed in this study. A statistical relationship was demonstrated between the formal preparation of the respondent and her perception of change.

2. The repetition of institutes at suitable intervals was implied by the responses of those who perceived few or no changes, yet felt that benefit accrued from the institute through reaffirmation of current performance.

3. The data revealed that the less experienced head nurses had difficulty in retaining all they had learned in the intensive two day institute and that, while their practice changed significantly, it tended not to reach the level made possible by the institute. The necessity for repeat institutes or progressive educational programs was therefore implied.

4. Some method needs to be found to encourage and support administrators in the upgrading of their staffs.

5. The study revealed that changes occurred in practice but without any knowledge of how or why they occurred. It is implied that institutes on the process of change or on the adoption of innovations would be valuable for senior administrative staff.

6. The use of institutes or interinstitutional group sessions, tutorials, or conferences should be an integral part of correspondence course education. The N.U.A. course is an excellent example of this. The process has also been standardized for External (correspondence) Studies by the University of New England, Armidale, New South Wales, Australia. (see its calendar)

C. Further research.

1. Other than that the participants should be head nurses, no selective process was used for admission to the institute under study. The institute was designed in advance of any study of the needs of the participants, i.e., their needs were assumed. Evaluation studies of educational offerings should continue to aid in the planning of future offerings and in the selection of participants so that needs and presentations may be matched.

2. The credibility situation discussed in this study implies a need for a similar study with the addition of a control group and the predetermination of evaluation practices for both groups, so that the effect of the institute could be more nearly ascertained quantitatively.

3. A study of attitude and practice change following differing forms of continuing education is implied, e.g., institute, workshop, correspondence course, etc.

4. A study of hospital settings is indicated to identify those factors which facilitate or deter change.

5. A study of professional opinion related to a given set of facts is implied to establish the credibility of professional opinion.

6. A study is indicated to determine the best way to increase the reading habits of nurses.

7. To establish the relationship of background data to learning, similar studies in evaluation would appear to need a proportionally greater sample of the population.

8. Studies of the interaction of staff members are indicated to determine the influence on this of changed behavior of head nurses, and,

conversely, its influence on change in practice by head nurses.

9. A quantitative study is indicated on the change in the performance of staff resulting from more democratic attitudes in human relations between the head nurse and her staff.

10. Studies in the evaluation of orientation procedures are implied if continuing education for nurses is to be designed from an established point of departure.

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APPENDICES

APPENDIX A

THE NURSING UNIT ADMINISTRATION CORRESPONDENCE COURSE

(THE N.U.A. COURSE)

The Canadian Nurses Association and the Canadian Hospital Association have jointly sponsored an extension or correspondence course in Nursing Unit Administration for head nurses in Canada since 1960. The course is described by its sponsors as an inservice type of program designed "to define the functions of administration and to show how these may be carried out in the management of the nursing unit." It is primarily designed for those who have been promoted into supervisory positions without adequate preparation and are unable to attend a university to upgrade their skills.

In 1966 an evaluation of this course was done with the aims of evaluating whether the purpose of the course was being met, examining the efficiency of the method, and forming guide lines for future action. Information was gathered in personal interviews across the country from the tutors who marked the lessons, graduates of the course, entering students, hospital administrative personnel, and nursing and university consultants.

The results showed that the course is well known and well thought of by hospital personnel. Graduates have been the best public relations tool. Cooperation for students to attend the associated work-

shops is high, although most students pay their own expenses. Many changes have been suggested for the course and for employing hospitals by the graduates and students. The course stimulated more reading for its students, and also suggestions by the students for other staff.

APPENDIX B

INSTITUTE INTERVIEW

1. Name _____ No. _____

2. Marital Status

   1. Single
   2. Married
   3. Widowed, divorced or separated

3. If married, husband's occupation _____

4. Number of children

   1. 0 - 5 years
   2. 6 - 10
   3. 11 - 15
   4. 15 or over

5. Age

   1. under 25 years
   2. 25 - 29
   3. 30 - 34
   4. 35 - 39
   5. 40 - 44
   6. 45 - 49
   7. 50 - 54
   8. 55 - 59
   9. 60 - 65

6. Gross annual salary

   1. under $3000
   2. 3000 - 3999
   3. 4000 - 4999
   4. 5000 - 5999
   5. 6000 - 6999
   6. 7000 - 7999
   7. 8000 - 8999
   8. 9000 or over

7. Names of organizations belonged to in past year, excluding church membership but including church organizations.

Total Score _____

Name of Organization	Attendance	Financial contribution	Member of Committee	Offices Held
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
Total (X1)	(X2)	(X3)	(X4)	(X5)

Score
0
1 - 5
6 - 10
11 - 15
16 - 20
21 - 25
26 - 30
31 - 35
Over 35

8. What was the highest grade of school you completed?

1. Some high school
2. Junior matriculation or high school graduation
3. Senior matriculation or first year university
4. 2 years university
5. 3 years university
6. over 3 years university

9. Where did you take your basic nursing course?

1. B.C.
2. Canada (other than B.C.)
3. United States
4. Great Britain
5. Other, specify. _____

10. Year of graduation

1. 1920 - 1929
2. 1930 - 1939
3. 1940 - 1949
4. 1950 - 1959
5. 1960 - 1967

11. What type of hospital or institution was your course associated with? _____

12. Post basic nursing education (give year).

    1. None
    2. CNA Correspondence course in ward administration
    3. University diploma course in
        a. public health nursing
        b. administration
        c. supervision
        d. teaching
        e. psychiatry
        f. other, specify _____
    4. University degree(s)
        a. degree(s) _____
        b. specialty _____
    5. Other, specify _____

13. In the past five years, have you taken any nursing courses not covered in the previous question?

    1. None
    2. Course _____ Institution _____

14. What post high school training have you had other than nursing?

    1. None
    2. Business
    3. Secretarial
    4. University degree, specify field _____
    5. Other, specify _____

15. In the past five years have you taken any non-nursing courses?

    1. Yes
    2. No

16. Are you interested in further courses in adult education?

    1. Yes
    2. No

17. How many years of experience have you had in nursing? _____

18. For how many years have you been a head nurse? _____

19. What is the approximate bed count of your hospital? _____

20. What type of nursing unit are you working on? _____

21. What is the bed count of the nursing unit? _____

22. What number of personnel does your unit have? _____

23. Kropp Verner attitude scale score.

24. What did you learn that was new at the Institute?

    How have you changed your evaluative procedure since the Institute?

APPENDIX C

STRUCTURED FORMAT FOR PERCEIVED CHANGE

I. No change

II. Change

A. Knowledge

1. Reawareness of previous knowledge.
2. Better understanding of the reasons for evaluation.
3. Better understanding of preparation of evaluations.
4. Better understanding of recording or writing evaluations.
5. Better understanding of discussing evaluations.
6. Others have similar problems.
7. There are other points of view besides one's own.

B. Attitude

1. Different feeling about interviews.
2. Different philosophy about evaluations.
3. Evaluations are easier to do now.
4. More confidence in doing evaluations.
5. Expectations are now two way.
6. There are other points of view besides one's own.
7. More confidence in ability to fill position.

C. Practice

1. Supervision

a) more observant of staff performance.

b) more explanations and reasons to staff.

c) more diplomatic and tactful.

d) problems dealt with immediately.

2. Teaching

a) teaching planned on observations of performance.

3. Orientation

a) now doing orientations.

b) planning new orientation.

c) outlines expectations and/or job descriptions.

d) more time spent with new staff members.

e) orientation more specific and more detailed.

4. Anecdotal notes

a) anecdotal notes now collected.

b) more anecdotal notes kept.

c) anecdotal notes more specific and objective.

d) collects anecdotal notes written by other staff.

e) collects and records comments on staff by doctors and patients.

5. Evaluation reports

a) more objective.

b) more future oriented.

c) more careful in describing behavior.

d) easier because more confident of facts.

e) more head nurse discussions of evaluation.

6. Interviews

a) more regular.

b) more frequent.

c) more informal.

d) more two way discussions.

e) more private and more planned.

f) more praise and encouragement given.

g) more specific.

h) more objective.

i) easier because reports are better.

j) easier because facts are available.

APPENDIX D

THE KROPP VERNER ATTITUDE SCALE

From the statements below, which most closely describes your opinion of the Institute on Evaluation which you attended?

1. It was one of the most rewarding experiences I have ever had.
2. Exactly what I wanted.
3. I hope we can have another one in the near future.
4. It provided the kind of experience that I can apply to my own situation.
5. It helped me personally.
6. It solved some problems for me.
7. I think it served its purpose.
8. It had some merits.
9. It was fair.
10. It was neither very good nor very poor.
11. I was mildly disappointed.
12. It was not exactly what I needed.
13. It was too general.
14. I did not take any new ideas away.
15. It didn't hold my interest.
16. It was much too superficial.
17. I left dissatisfied.

18. It was very poorly planned.

19. I didn't learn a thing.

20. It was a complete waste of time.

APPENDIX E

THE LEARNING SITUATION

Learning is defined in the behavioral sciences as a change in behavior which is more or less permanent.[1] The definition is applicable to knowledge, attitude and skills, although only knowledge can be objectively measured. If new behavior is to be learned, the learner must have knowledge about this new behavior, attitudes which are positive toward this new behavior, and a situation where he can practice or use it. Acquisition of new behavior is, therefore, dependent upon learning, a need to change, a climate conducive for learning, and approval of the co-members of one's groups.

Knowledge

Knowledge is the acquisition of facts about one's world, and the frames of reference or cognitive configurations which the individual develops to keep his information classified, systematized, or logically sequenced.[2] Our cognitive world is constructed on what we think, believe, and expect. Hence, "the responses of the individual to persons and things are shaped by the way they look to him--his cognitive world."[3] As each person has a different experiential background, each has a different cognitive world. An egocentric assumption that 'our' cognitive world is the same as that of others leads to confusion and difficulties in interactions, communication and understanding.[4]

By the time a person is an adult, he has usually developed complex cognitive structures which he uses as anchors for any new material with which he is presented. These structures are concepts, which form as the person organizes, groups, and systematizes his knowledge. Harvey defines a concept as a mode of relatedness between the individual and his world.[5] When the person is presented with new material, he accepts and stores it in his memory. If the material has no relationship to anything he has stored before, he is likely to discard it, but if it is related to previous concepts, he adds it to his previous cognitive configurations by modifying these, or adding to them. On the whole, we do not like to change things too drastically as this would destroy our relationship with "our" world. We are more likely to distort the information we have received so that it will fit our preconceived concepts, even though these may have been formed with too little information. (This will be further discussed under Attitudes) Human beings dislike ambiguity or gaps in knowledge, and tend to bend or fill in what they already 'know' with fantasies and imagination. If nothing is presented to amend this, the person may have faulty concepts about many subjects. New information will change these concepts only in so far as the individual is willing to accept new ideas and change his cognitive patterns.

Usually concepts form from simple to complex, from concrete to abstract, and from discrete to systematic. Educational offerings should be based on a similar sequence.[6,7,8] The individual also strives for a logical consistency in this process of cognitive patterning. This does not always occur, however, because of changes which are constantly taking

place in ourselves and in our world. The concepts one holds are reinforced and modified continually by the reactions of those around us as we seek their approval of our actions.[9] As a person develops maturity, there is a development of logical interrelatedness between his various concepts, giving his personality an integration of values and knowledge.[10] Concept formation and change occur readily for the integrated or 'open' person, since he can examine material readily. When a lack of interrelatedness leads to compartmentalization of concepts, rigidity and a 'closed' personality develop.[11] As concept formation and change are basic to problem solving, the open person is more likely to seek alternative pathways when an apparent solution is not tenable.[12]

Attitudes

Attitudes are the emotional components of the facts which a person stores, or the "feeling tone" about these ideas or concepts.[13] They become a part of cognitive configurations as these develop throughout childhood and adulthood.[14] Attitudes will have a decided influence on what a person can accept or use to alter cognitive patterns. Sherif states that an attitude is not a point on a continuum, but rather a range of latitude of acceptance.[15] Attitudes define what a person is and what he is not. Halloran describes attitudes as being our major equipment for dealing with reality, and, as such, they reflect our style of operation in coping with problems and in simplifying complex situations so we can deal with them.[16] Attitudes are learned along with knowledge and are built into cognitive concepts as these form. The greatest source of influence on attitude formation is the interpersonal relationships one

has with important or significant others.[17] Thus, those in our groups at work or at home, will have a decided effect on how we feel about things and persons.[18]

Attitudes toward any new material add new dimensions to whether or not a person can 'learn' the material. If new material is within the 'latitude of acceptance', it will be handled as described on page 126, modifying or adding to existing cognitive configurations. However, if the material is outside his range of acceptance, the person will either reject it completely as meaningless to him, or he will change it in some way to make it acceptable. This is how people 'twist facts' or distort reasoning.[19]

Attitudes have degrees of emotional effect for the individual also, because they are part of a concept that is more or less meaningful to that individual. When a concept is very meaningful, it is well protected with defense mechanisms. Such a concept is considered a 'central concept', and has a low range of acceptance for change. The most central concept for most people is that of self. When new information pertains to a central concept, it will be accepted if it confirms his concepts, but rejected if it does not. A less meaningful concept has less emotional content, and is not so readily defended. Such a concept is considered a peripheral concept, and has a wide range of acceptance for change.[20] Thus, the person with most of his concepts in the peripheral sphere is more readily influenced than the person with a great number of central concepts.[21,22]

Practice

Skills are ways of behaving in coordinated, smooth, precise patterns as responses to the stimuli or cues of a situation.[23] Practice is usually defined as the repetition of learned sequences of behavior until the pattern is automatic or has become a habit.[24] Confusingly, in nursing, practice is used to denote the person 'practicing' nursing or working as a graduate nurse. Her skills are accepted as already acquired, although interpersonal relationship skills never become automatic. Thus in this paper the term practice has been used to denote the acquired skill rather than the acquisition of it.

In the acquisition of a new skill, the individual starts from a background of many already existing, highly developed general and specific skills. Each adult has hundreds of these skills, each skill with its own background of cognitive patterning.[25] As a person begins a new routine, he tries one of his existing habit patterns. From his internal feedback of 'feel' and the responses of his environment, he will adjust the pattern he tried, or try another. His original repertoire of responses and habits influence this markedly.[26]

Performance during the learning of a skill can be described as passing through the stages of cognition, fixation and automation.[27] The cognitive stage is the early stage, during which the person acquires the knowledge necessary for him to perform the behavior for which he is striving. This stage is one of confusion as the person makes many errors of wrong responses, or right responses at the wrong time. He has to learn the stimuli or cues in his environment which are relevant and irrelevant to his task.[28] Gradually he learns to match appropriate cues

and responses as his information processing improves and his cognitive configurations develop. Fixation is the stage during which he refines his responses through further selection and discrimination. This is the longest period in learning a skill.[29] Gradually there are decreasing errors and increasingly smooth, precise and accurate responses. At this point automation or habit patterns have been established. (Fitts describes a cognitive set or habit as the preparation in advance for the probabilities or contingencies characterizing a certain situation.)[30] Skill learning therefore is a gradual shift in the factor structure of the skills as units become larger and cognitive sets or habits develop. The discontinuity of movement is lessened, and continuity becomes smooth.[31]

The Need to Change

Often a satisfactory and acceptable degree of competence in old patterns of behavior makes a person unwilling to relinquish the security his competence gives him for the untried and uncertain reactions the new behavior may produce. The new behavior seems less necessary or important to him than to someone who does not have satisfying patterns of behavior.

For learning to occur, the person must desire a change or something must be done to induce him to feel a need to change. For some, extrinsic rewards may be supplied through promotion, increased pay, encouragement, praise or other means which are meaningful to the learner. For others, the intrinsic gratification of learning alone is enough.

Role prescriptions provide some of the major motivations to change. Role is defined as "the pattern of wants and goals, beliefs,

feelings, attitudes, values and actions which members of a community expect would characterize the typical occupant of a position. Roles prescribe the behavior expected of people in standard situations."[32] A position is defined as "a category or place in a system of social classification . . . recognized by a community. Each individual occupies multiple positions, associated with each of which is its role."[33] Merton states that the individual behaves in "regular role performance as a logical consequence of the system of sanctions imposed on those who fail to meet, and rewards those who do meet, the expectations of society."[34]

There are always incompatibilities within one role, and incompatibilities between roles.[35] The way an individual behaves in his roles reflects both his personality and the incompatible and conflicting demands and expectations of others. Role conflicts are solved through the person's decisions regarding the importance of others' expectations, and the punishments he may receive for noncompliance. When the role is not clearly defined, as often happens, the person has further conflicts with which to contend.

The conflicts and incompatibilities in a role cause much pressure on the incumbent of a position. When a person is new to the position, the various attributes of the role can be both confusing and conflicting. When solutions are not within sight, the incumbent may react with the behavior of her old position, becoming more and more dissatisfied as this behavior fails to resolve her conflicts.[36,37] Some of the problems are societal commonalities, such as those for anyone in a similar position; some are organizational with incongruent authority

and responsibility in the position; and some are personal when the individual cannot resolve incongruent personal and role goals.

Within the nursing profession, there are often additional pressures arising from directing the work of others instead of doing actual patient care.[38,39] The nurse who has risen to a head nurse position has to conform to the norms of her new role and dissassociate herself from the group which she has left. For her new role she has to learn the values, attitudes and behaviors of the head nurse group, and how these differ from those she learned during her occupational socialization in becoming a staff nurse.[40] This change requires major changes in self concept for many nurses with considerable insecurity until the new role attributes are learned.[41,42,43,44] The ability to make adjustments and the experiential background of the individual determine the facility and ease with which she adjusts.[45,46,47]

Regardless of the extrinsic or intrinsic motivation, however, the person must desire the change. He has to perceive the change as useful to him, and adaptable to his past experience and his present social system.[48] By this it is meant, that he has to realize the use or meaningfulness of the new behavior to him through being able to relate it to what has happened to him in the past, and through his perception of the acceptability of the new behavior to those in his social groups. Whatever engenders a feeling of a need to change, the person tries to acquire the information he needs for the new behavior and to develop the attitudes he needs to adopt it. These are often influenced by the climate in which the new material is presented.

Climate for Learning

The learner needs a clear picture of the behavior or knowledge which he is to acquire, and an opportunity to practice any change for reinforcement of the new behavior. Information can be presented in many ways and under many different circumstances. Some of the ways which have been found conducive to learning were discovered through classroom experiments,[49] others were discovered through research into public opinion,[50,51] and much has been learned through trial and error.

Freedom from threat, permission to ventilate feelings, emotional support, and an opportunity to gain insight into one's feelings about the subject under consideration have been found to enable learning to occur. The degree of each of these required by any one individual will be dependent upon his knowledge and attitudes, and by the amount of change desired.[52]

Mild anxiety is necessary for learning to occur as complacency, apathy, and disinterest in change are characteristic of minimal anxiety.[53] Excess anxiety, however, leads to the activation of defense mechanisms and hence decreased communication and learning.[54]

Often the credibility of the communicator in the perception of the learner, the form and manner of the presentation, and the circumstances of the delivery have pronounced effects on the learner.[55,56,57]

The Effect of Small Groups

> Man is a social being and . . . is dependent upon others to a considerable degree. He has lived, played, worshipped, worked, and has been educated in groups throughout his

> existence. The worst punishment which society can inflict upon him is the living death of isolation . . . . The continuity of mankind has been primarily through small groups: it cannot endure without them.[58]

A person's membership in any group depends upon how well his aspirations and objectives are congruent with those he perceives as the norms of his group.[59] The more he participates in forming group consensus, the more involved his membership becomes. With greater involvement, there is more conformity, liking, security. When group approval is not apparent, the member may experience frustration and conflict.[60] A work situation is particularly vulnerable in this respect as changes in personnel bring changes in group membership and group norms. A new group member will often conform to patterns which previous group members have found comfortable and satisfying, in order to gain acceptance. On the opposite extreme, a lack of defined expectations may result in frustration and conflict for all group members.[61,62]

The successful worker, who was well accepted within his work group may feel cut off from his former associates when he is promoted to a supervisory position. He is now expected to conform to the behavior of his new group and former co-workers expect leadership from him. Adjustment to a new role is easier with a well organized plan of orientation, and encouragement and support as needed.[63]

It is the responsibility of the supervisory person to plan for changes in the work group. Unless he gains his subordinates' cooperation, little will happen. Cooperation is facilitated by mutual planning of objectives and discussions of accomplishments. The motivation to change

is often the result of the group process and is most effective when it is engendered and reinforced within the group.[64,65,66,67,68]

Conferences, workshops, institutes or other meetings of those in similar positions in different agencies, stimulate and encourage the potentials for "learning, reorientation, and creative thinking" already present in those who attend.[69] Group process is definitely a factor at such gatherings, and can be used constructively to influence change.

The social system of each small group possesses a structure of interaction or a relational system, a system of customary behavior and a system of values.[70] These systems are interdependent and thus enhance and support each other. A social system exists in a certain environment, and changes in either are reciprocal. The relational system is one of interpersonal relationships built upon responsiveness, understanding and sensitivity to others. The customary behavior and the value system govern how group members should behave and feel.

> Personal life satisfaction . . . depends upon our communion with people . . . . Society can only be understood through communication; it can only stay together as a society by proper communication . . . . Dialogue . . .begins in an act of faith: the assumption that those who converse speak in honesty for the purpose of reaching understanding, and with generosity toward each other . . . . Dialogue demands that we earn the right to be heard by lending our ears to what others have to say. The only way we can get another person's idea of ourselves and our projects is by listening to him talk.[71]

Communication is the process of a sender encoding and transmitting a message which is received and decoded by a receiver.[72] When there is no blockage, the recipient understands the message which the

sender meant him to receive. The composite parts of the process include a similar language symbolism, the emotional component of the message to either the sender or the receiver, the nonverbal aspects of the communication sent, the attitudes engendered in the receiver, and the relevance of the material to the receiver.[73,74,75]

Communication and interaction are inseparable. Much interaction is spontaneously evolved and each encounter leads to feelings on a continuum between acceptance and rejection. The prime motivation in any interaction is the validation and protection of the self. Past experience will determine the quality of an individual's response and the extent to which he perceives other persons, events, and situations as threats.[76] This perception influences the activation of his defense mechanisms and hence his ability to communicate. In threatening situations, which can occur for anyone, the person may not perceive the information which is available, he may misinterpret it to bring it into line with existing concepts, or he may receive the information adequately but be unable to respond through ignorance or fear.[77]

Communication is increased when the subject is important to the group, when the group is cohesive, when friendships exist in the group, and when the group is small. With increasing membership in a group, there is increasing heterogeneity of ideas and decreasing individual participation and involvement.[78] In very large groups, the 'anonymity phenomenon',[79] or alienation from group membership may occur.[80] Either of these may lead to a lack of expectations of performance, and a lack of responsibility and participation in group endeavour.

Presentation of New Material

When the objectives of a presentation or lecture appear to be congruent with the worker's personal objectives, he is more receptive to the new information. As meaningfulness is evident, he can relate it to earlier experience through the reorganization of his existing concepts.

> The retrainee is quite a different individual than the young trainee. Our experience with this group shows them to be . . . far more highly motivated, realistic, insightful, responsible, and generally more stable. Their goals are generally fixed, long-range in nature, job oriented, and they are far more strongly committed to these goals than are the younger students.[81]

Many of the courses or lectures which people attend do not present 'new' material but rather information which the person had earlier received and stored. The 'refresher' course tends to bring into consciousness this 'forgotten' material.[82] If the material is presented in a different context or from a different point of view it becomes related more meaningfully to existing concepts. In this way the person will be more likely to use it.[83,84] Personal growth is dependent upon the incorporation of the new with the old, or in bringing into meaningful focus previously learned information.

At an institute where small group discussions are employed, an individual tends to become involved in the group process. In so doing, he expresses his ideas and thoughts to group members, and receives feedback from them. The approval or disapproval inherent in group participation may alter his feeling of a need to change. Within the small group the person often discovers that his major problems are those common to his position. These problems may be the societal commonalities mentioned earlier, or they may be of organizational origin, only extant in his

employing agency, or only in a specific type of agency.

The group may give the person feelings of adequacy and competency which were lacking earlier as he was not aware that others shared the same problems. He may also find that his own personal solutions are deemed adequate by his peers. The group may, on the other hand, make him realize that there are better ways of solving problems than those he had been using and motivate him to try new behaviors. The interactions and communication patterns within a small group can have a major influence on the group members. Especially when change is to be effected and new material is to be learned, consideration of the group process is important.

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